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BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Administrator Of Veterans Affairs

Second-Year Implementation Of The Federal Managers' Financial Integrity Act In The Veterans Administration

GAO reviewed second-year progress made by the Veterans Administration (VA) and 22 other federal agencies in implementing the Federal Managers' Financial Integrity Act. The act is intended to help reduce fraud, waste, and abuse in federal government operations through annual assessments of internal controls and accounting systems.

VA has made progress in setting up a framework for evaluating and reporting on its internal controls and accounting systems and demonstrated a strong commitment to strengthening and improving these systems. But VA reported significant instances of uncorrected problems and nonconformance with standards set by the Comptroller General for implementation of the act, and GAO identified other problems with VA's internal control process. VA internal control reviews and assessments need improvement, further participation by field facilities is needed, there should be increased consideration of ADP controls, and VA should broaden the scope of its accounting evaluations and improve testing of its accounting systems.

VA cannot yet state, GAO believes, that it has adequately fulfilled the objectives of the act or that its accounting systems conform to the Comptroller General's requirements. To be able to report this, VA needs to improve its evaluations of its internal controls and accounting systems. GAO makes specific recommendations for such improvements.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-216946

The Honorable Harry N. Walters
Administrator of Veterans Affairs

Dear Mr. Walters:

This report presents the results of our review of efforts by the Veterans Administration (VA) to implement the Federal Managers' Financial Integrity Act of 1982 (31 U.S.C. 3512 (b) and (c)). Our review was part of a General Accounting Office assessment of 23 federal agencies' implementation of the act during the second year.

As you know, 31 U.S.C. 720 requires you to submit a written statement on actions taken on our recommendations. You must send the statement to the House Committee on Government Operations and the Senate Committee on Governmental Affairs within 60 days of the date of this report and to the House and Senate Committees on Appropriations with VA's first request for appropriations made more than 60 days after the date of this report.

We are sending copies of this report to the Chairmen, House and Senate Committees on Veterans' Affairs and Appropriations, and the Director of the Office of Management and Budget.

Sincerely yours,

Richard L Fogel

Richard L. Fogel
Director

EXECUTIVE SUMMARY

Concern over continuing disclosures of waste, loss, unauthorized use, and misappropriation of funds and assets in a wide range of government operations led the Congress to enact the Federal Managers' Financial Integrity Act in August 1982. It strengthened requirements for federal agencies to improve their systems of accounting and internal controls.

To assess implementation of the act by the Veterans Administration (VA) and other federal agencies, GAO reviewed their progress in evaluating the adequacy of agency internal controls and accounting systems and identified improvements needed.

VA programs have an enormous effect on the lives of millions of Americans. For fiscal year 1985, the Congress appropriated $26.3 billion to ensure that benefits and services would be provided to the nation's 28 million veterans and their dependents.

BACKGROUND

Under the Federal Managers' Financial Integrity Act, federal agencies use Office of Management and Budget (OMB) guidelines to evaluate their systems of internal accounting and administrative controls to determine whether the systems provide reasonable assurance that the objectives of the act are met. The OMB guidelines give an agency a framework for organizing the process, segmenting the agency to create an inventory of assessable units, conducting vulnerability assessments, performing internal control reviews, taking necessary corrective actions, and reporting annually to the President and the Congress on the status of its internal controls and accounting systems.

In December 1984, the Administrator of Veterans Affairs issued his second annual report on the status of VA's internal controls and accounting systems. He reported that VA had reasonable assurance that the objectives of the act were achieved, but identified 14 areas of material weakness in internal controls and instances of nonconformance of its accounting systems with the Comptroller General's requirements.

RESULTS IN BRIEF

VA made progress in establishing a framework to evaluate and report on the status of its internal controls and accounting systems. It continues to demonstrate a strong commitment to strengthen its internal controls and improve its accounting systems. There is, however, a continuing need for VA to improve its assessments and reviews of internal controls and to increase the testing of its accounting operations.

GAO believes that, due to the problems identified in the internal controls evaluation program, VA lacks an adequate basis at this time to state whether its internal control systems as a whole comply with requirements to provide reasonable assurance that the objectives of the act were achieved. Given the limited nature of VA's evaluation program, the uncorrected material weaknesses and instances of nonconformance VA reported further detract from the reliability of its reasonable assurance statement. Also, in GAO's opinion, VA is not yet in a position to report on whether its accounting systems conform to the Comptroller General's requirements. (See chs. 2 and 7.)

PRINCIPAL FINDINGS

Progress Was Made

In response to suggestions made by GAO last year and concerns expressed by OMB, VA changed its agency-wide internal control directive. Based on the revised directive, VA conducted vulnerability assessments and preliminary and internal control reviews. In doing so, VA identified some problems and material weaknesses, which it has begun to correct. In addition, the agency finalized guides for conducting preliminary and internal control reviews, and automated its tracking and follow-up system for internal control activities. (See ch. 2.)

Reviews and Assessments Need Improvements

For evaluation of controls, vulnerability assessments generally lacked adequate documentation, and assessment forms lacked essential steps. Preliminary reviews generally did not present adequate plans for implementing review recommendations and sometimes lacked sufficient analysis of issues being addressed. (See ch. 3.)

Internal control reviews covered some significant activities, such as the $3.9 billion pension and $1.5 billion education programs. Most reviews, however, did not complete all prescribed review tasks or include an adequate examination of internal controls. Also, our analysis showed that resulting recommendations were sometimes too general or not implemented. Moreover, VA did not centrally direct any reviews of internal controls of its $8.6 billion medical care program, although it reported material weaknesses in this area. (See ch. 4.)

Further Field Participation Needed

The effective implementation of the act at VA field facilities--regional offices and medical centers--is an important facet of the agency's overall internal control efforts. Located in every state, the District of Columbia, Puerto Rico, and the Philippines, these facilities spent over 95 percent of the agency's fiscal year 1984 appropriations but did not adequately assess their internal controls.

GAO found that VA did not require internal control evaluations of its regional offices and medical centers did not conduct evaluations in a consistent manner. Field facilities did not review some crucial operations, nor did long-established systematic management reviews adequately consider internal controls. In fiscal year 1984, regional offices did not have to provide assurance that their internal controls and accounting systems complied with the act's objectives, although they administered $15.9 billion in veterans' benefits--about 62 percent of the VA budget. (See ch. 5.)

ADP Controls Need Increased Consideration

The agency's ADP systems disbursed about $15.9 billion in veterans' benefits and supported the $8.6 billion medical care program. VA operated over 700 computers at its 5 data processing centers and 169 computer centers at its 172 hospitals. VA made little progress since last year in considering ADP controls as part of its internal control assessments and reviews, GAO found. For example, VA's review of its $3.9 billion pension program did not adequately consider ADP controls, which are essential to program reliability and integrity. (See ch. 6.)

Accounting Systems Evaluations Need Improvements

By identifying some significant areas of nonconformance with the Comptroller General's requirements through limited tests of disbursements in its six major accounting systems, VA made progress in evaluating its accounting functions. VA, however, needs to broaden the scope of its evaluations and improve the quality of its tests. Therefore, GAO believes that, until the accounting systems have been adequately evaluated in operation, VA should not report that they conform with the Comptroller General's requirements. (See ch. 7.)

RECOMMENDATIONS

GAO's recommendations to improve evaluations of internal controls and accounting systems, if implemented, should give VA an adequate basis to state in its future reports to the President and the Congress whether it has reasonable assurance that its internal accounting and administrative controls comply with the objectives of the act and its accounting systems conform with the Comptroller General's requirements. (See pp. 23, 32, 43, 54, and 64.)

AGENCY COMMENTS AND GAO EVALUATION

In responding to a draft of this report, VA concurred with GAO's recommendations but expressed reservations about the need to implement them in precisely the manner GAO recommends. VA also disagreed with GAO's conclusion that VA lacks an adequate basis to provide reasonable assurance.

In GAO's opinion, unless the agency's key accounting systems and internal controls over major programs and functions are adequately evaluated and tested, the agency head lacks an adequate basis to conclude whether the systems as a whole provide reasonable assurance. Evaluations and corrective actions needed to address the act's requirements may take several years to complete. An agency may be making good progress toward that goal, yet not have progressed to the point where reasonable assurance can be provided. GAO also believes that, until corrective actions are implemented and tested, the material weaknesses that the actions are intended to address detract from the reliability of a statement of reasonable assurance for the systems as a whole. (See pp. 11 and 12.)

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I.1 Veterans Administration process for compliance with the Federal Managers' Financial Integrity Act 66

ABBREVIATIONS

ADP	automated data processing
CALM	Centralized Accounting for Local Management
DM&S	Department of Medicine and Surgery
DVB	Department of Veterans Benefits
FMFIA	Federal Managers' Financial Integrity Act
FY	fiscal year
GAO	General Accounting Office
ICR	internal control review
OB&F	Office of Budget and Finance
ODM&T	Office of Data Management and Telecommunications
OIG	Office of the Inspector General
OMB	Office of Management and Budget
VA	Veterans Administration

CHAPTER 1

INTRODUCTION

Responding to continuing disclosures of fraud, waste, and abuse across a wide spectrum of government operations, the Congress in August 1982 passed the Federal Managers' Financial Integrity Act (FMFIA) (31 U.S.C. 3512(b) and (c)). It is intended to strengthen the Accounting and Auditing Act of 1950, which places the responsibility for establishing and maintaining systems of accounting and internal control upon the head of each executive agency.

The Federal Managers' Financial Integrity Act provides a framework for federal departments and agencies to identify their major internal control weaknesses and accounting system problems and develop effective management control systems and sound financial management structures. To achieve these ends, the act requires:

--The Comptroller General to prescribe standards for federal agencies' internal accounting and administrative control systems. The Comptroller General issued internal control standards in June 1983.

--Each agency to establish and maintain its internal accounting and administrative controls in accordance with the standards prescribed by the Comptroller General and provide reasonable assurance that: (1) obligations and expenditures comply with applicable law; (2) funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and (3) revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the assets.

--Each agency to evaluate and report annually on internal control systems. The report is to state whether agency systems of internal control comply with the objectives of internal controls set forth in the act and with the standards prescribed by the Comptroller General. To the extent systems do not comply, the act also requires agency reports to identify the material weaknesses involved and describe the plans for corrective action.

--Each agency to prepare a separate report on whether the agency's accounting systems conform to principles, standards, and related requirements prescribed by the

Comptroller General. The Comptroller General issued a statement of accounting principles and standards in April 1983, revised in November 1984.

--The Office of Management and Budget (OMB) to issue guidelines for federal departments and agencies to use in evaluating their internal accounting and administrative control systems. OMB guidelines were issued in December 1982.

The Veterans Administration (VA) is 1 of 23 agencies included in our review of the status of federal agencies' efforts to implement the act. This is our second report on VA's implementation of FMFIA. Our first report,[1] identified weaknesses in VA's FMFIA procedures and proposed corrective actions.

OMB'S RECOMMENDED APPROACH FOR EVALUATING INTERNAL CONTROLS

The OMB guidelines provide a basic approach for evaluating, improving, and reporting on internal controls. OMB recommends the following process as an efficient, effective way to evaluate and report on internal controls:

--organize the process to ensure that it can be effectively managed;

--segment the agency to create an inventory of assessable units;

--conduct vulnerability assessments to determine the risk of waste, loss, unauthorized use, or misappropriation;

--develop plans and schedules for performing internal control reviews and other actions;

--review internal controls to determine if they are functioning as intended;

--take corrective actions for improving controls on a timely basis; and

--report annually to the President and the Congress on the adequacy of internal controls and plans for corrective action.

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[1] GAO, First-Year Implementation of the Federal Managers' Financial Integrity Act in the Veterans Administration (GAO/HRD-84-46, Apr. 27, 1984).

VA'S EVALUATION OF INTERNAL CONTROLS

VA's internal control directive outlines a broad framework for evaluating internal controls, following the OMB guidelines. It involves sequential steps for evaluating, improving, and reporting on internal controls (see app. I). The Deputy Administrator has overall responsibility for the agency's internal control efforts, including monitoring the efforts of its 22 organizational components (listed in app. II). The Associate Deputy Administrator for Information Resources Management and his Management Control Staff also provide administrative support to the Deputy Administrator in his internal control responsibilities.

Each component is to identify its assessable units[2] and conduct vulnerability assessments[3] at least once every 2 years in each assessable unit. In assessable units found to be highly or moderately vulnerable, a preliminary review[4] should be conducted followed by an in-depth review of internal controls, if such is warranted and resources permit. The components also are to plan and implement corrective actions, where appropriate.

If, at any stage in the process, the corrective action is readily apparent or the component determines that controls are in place and functioning adequately, subsequent review steps may be unnecessary. Each component is to report the results of this process in its periodic reports to VA's Management Control Staff, which monitors the evaluations of internal controls.

In fiscal year (FY) 1984, VA revised its internal control directive in response to suggestions in our report on its first-year efforts and to concerns expressed by OMB and VA components. Significant changes included assigning responsibility to assess common and crosscutting functions, involving field managers in the evaluation process, providing training to personnel, and establishing minimum requirements for documenting the evaluation process.

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[2] VA defines an assessable unit as the level at which a separate vulnerability assessment is conducted within a VA component. This may be the same as a program/administrative function or a segment of one.

[3] VA defines a vulnerability assessment as a measurement of the susceptibility of an assessable unit to the occurrence of waste, loss, and unauthorized use, or misappropriation.

[4] VA's preliminary review is an intermediate step between vulnerability assessments and internal control reviews.

Of VA's 22 components, 17 reported that they conducted vulnerability assessments in FY 1984. Five components had completed assessments in FY 1983, and in accordance with VA's directive, were not required to conduct assessments again until FY 1985. The 17 components reported that they completed 347 vulnerability assessments of which 24, or 7 percent, were rated highly vulnerable; 65, or 19 percent, moderately vulnerable; and 258, or 74 percent, as having low vulnerability (see app. III).

VA's internal control directive provides for conducting preliminary reviews following completion of vulnerability assessments to determine the appropriate follow-on action. These reviews are intended to help VA managers address problems, issues, or concerns highlighted during the vulnerability assessment and select the most appropriate action, including in-depth internal control reviews (ICRs) when warranted. During FY 1984, 10 of VA's components reported that they had performed 25 preliminary reviews (see app. IV).

The preliminary review is to be followed by an ICR if the findings are inconclusive or the problems seem serious. An ICR is a detailed examination of all or part of a VA component's system of internal control to determine whether adequate controls exist and are implemented to prevent or detect in a cost-effective manner the occurrence of potential risks. The agency reported that 7 of its 22 components completed 14 ICRs (see app. V) in FY 1984.

VA's Management Control Staff developed a tracking and follow-up system to ensure that vulnerability assessments, preliminary reviews, ICRs, and corrective actions are scheduled and completed on a timely basis. The staff requires VA component heads to submit quarterly and annual reports on the status of their internal control activities. These reports are to include, among other information, statements of written assurance on internal controls and on the status of material weaknesses and corrective actions, as well as completed and scheduled vulnerability assessments, and preliminary and internal control reviews. The staff uses the reports to summarize the results of internal control activities in VA and publishes a "master calendar" on the status of such activities for use by the Deputy Administrator.

FY 1984 REPORT TO THE PRESIDENT AND THE CONGRESS

On December 27, 1984, the Administrator of Veterans Affairs issued his letter report to the President and the Congress on the status of VA's internal controls and accounting systems. In his combined statement on their status, the Administrator reported that VA had reasonable assurance that its system of internal controls complied with the objectives of the act.

Based on the results of the internal control evaluation, assurances given by appropriate agency officials, and other information provided, the report stated that the VA system in effect during FY 1984 taken as a whole complied with the act to provide reasonable assurance that

--obligations and costs were in compliance with applicable law;

--funds, property, and other assets were safeguarded against waste, loss, unauthorized use, or misappropriation; and

--revenues and expenditures applicable to VA's operations were properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the assets.

Nonetheless, the agency's evaluation process identified 14 areas of material weakness (see app. VI) that indicate the potential for saving millions of dollars by improving policies and procedures in the administration of VA medical care programs, veterans' benefit programs, medical facility construction programs, computer security, and accounting operations.

According to VA's report, the agency's accounting systems in place during FY 1984 generally conformed in all material aspects to the Comptroller General's principles, standards, and related requirements. VA based this statement on the results of the accounting systems reviews, the approvals of its accounting systems already provided by the Comptroller General, and assurances given by appropriate agency officials.

The report identified significant areas, however, in which VA's accounting systems did not conform to the Comptroller General's requirements. Areas of concern included cash management, fund control, and reconciliation/follow-up on accounts in the Loan Guaranty and Centralized Accounting for Local Management systems.

REVIEW, ASSISTANCE, AND GUIDANCE PROVIDED BY OIG

VA's Office of the Inspector General (OIG) reviewed the agency's evaluation of its system of internal accounting and administrative controls to determine whether it was conducted in a prudent and reasonable manner.[5] The review included all major VA departments and offices and focused specifically on (1) actions to correct deficiencies cited previously by GAO and the OIG and (2) efforts to address and correct material weaknesses reported in VA's first annual report.

The OIG also offered technical assistance to VA components in several areas. For example, the OIG commented on the agency's internal control directive, Department of Veterans Benefits' (DVB's) pension and education program internal control reviews, Office of Data Management and Telecommunications (ODM&T) direct deposit/electronic funds transfer internal control review, and Department of Medicine and Surgery's (DM&S's) circular on internal control systems. The OIG also participated in developing and implementing DM&S's nationwide OMB circular A-123 training program and performed a vulnerability assessment of DVB's loan guaranty program. Further, the OIG included sections in its two 1984 semiannual reports highlighting the OIG's internal control review program.

In addition, the OIG revised its policy manual to include a section on the evaluation of internal controls in most of its cyclic and programmatic audits. Consequently, OIG audit reports are to include a status report on internal control weaknesses requiring management action.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to evaluate VA's implementation of FMFIA during the second year, examine existing systematic management review processes at VA medical centers and regional offices, and report on the status of its internal controls and accounting systems. Because our second-year review focused on an evaluation of the implementation process, we did not independently determine the status of VA's internal control systems. evaluate the effectiveness of its existing systematic management review processes, or determine the extent to which the agency's accounting systems conform to the Comptroller General's principles, standards, and related requirements.

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[5] VA/OIG, Comments on VA's Second-Year Efforts on Implementation of the Federal Managers' Financial Integrity Act (Dec. 28, 1984).

Our work was performed at VA's central office from June 1984 through May 1985. We compiled data on all organizational components that performed evaluations of internal controls and accounting systems. To evaluate the agency's performance of vulnerability assessments and preliminary and internal control reviews, we focused our review on six major organizational components: DM&S, DVB, ODM&T, Office of Construction, Office of Procurement and Supply, and Office of Budget and Finance (OB&F). These components accounted for over 99 percent of VA's budget. OB&F was selected also because it was responsible for evaluating VA's accounting systems.

We reviewed vulnerability assessments that were performed by four of the six components during FY 1984. These components conducted 293 of VA's 347 assessments, or about 85 percent. We then focused on 21 assessments conducted by these 4 components--13 from DM&S, 1 from ODM&T, 3 from Office of Construction, and 4 from Office of Procurement and Supply. These 21 assessments were judgmentally selected to obtain a comprehensive mix of major programs and activities, automated data processing (ADP), accounting operations, and areas that had overall ratings of high, moderate, and low vulnerability. The other two components--DVB and OB&F--were not required to conduct their second round of vulnerability assessments because they performed them in FY 1983. Our examination of preliminary reviews covered 7 of 25 reviews performed by four of the six components--DM&S, DVB, Office of Construction, and Office of Procurement and Supply--during FY 1984.

To assess ICRs, we analyzed 10 of the 14 reviews reported by three of the six components--DVB, OB&F, and ODM&T--and discussed several with ICR team members. Then we focused on two of these in more depth by contacting all team members, reviewing ICR documentation, and discussing review results and corrective actions with central office and regional office managers. We selected DVB's reviews of the pension and education benefit programs for this in-depth study, because both were costly programs in which VA identified material weaknesses during FY 1983.

To review VA's field facilities' participation in the internal control evaluation process, we visited 6 of its 172 hospitals, 3 of its 7 regional medical education centers, 7 of its 58 regional offices, 3 of its 5 data processing centers, and the Philadelphia Insurance Center between July 1984 and January 1985 (see app. VII). The field facilities we selected were geographically dispersed and varied in size and in services offered. We believe these facilities represent a good cross-section of VA's field operations.

At each field facility, we interviewed officials and reviewed records regarding their evaluation of internal controls. We then focused primarily on the medical centers and regional offices because they administered almost 95 percent of VA's budget. At the regional offices, we interviewed internal control officers and division chiefs and examined 1983 statements of written assurance, performance plans, and informal tracking and follow-up systems. At the medical centers, we interviewed management review program coordinators and service chiefs, and reviewed 1984 statements of written assurance, vulnerability assessments, preliminary and internal control reviews, and informal tracking systems.

In addition to interviewing officials and reviewing records at the medical centers and regional offices, we reviewed the DVB and DM&S guidance provided to field facilities to evaluate their systems of internal controls. We also reviewed reports conducted under the existing systematic management review processes such as DM&S's Systematic External Review Program and Systematic Internal Review and DVB's Statistical Quality Control and Systematic Analysis of Operations to determine whether they were adequate substitutes for internal control evaluations. At the medical centers, we reviewed reports issued by the Joint Commission on Accreditation of Hospitals to identify weaknesses that should have been included in the internal control tracking system to assure corrective action.

The methodology for our examination involved reviewing guidance, instructions, vulnerability assessments, preliminary and internal control reviews, quarterly and annual reports, "master calendars" that summarized internal control activities to support VA's annual statement, and other records which documented the evaluation process. We reviewed VA's internal control directive issued in September 1984, as well as various memoranda from top level agency officials which provided guidance and instructions on implementing OMB circular A-123 (revised). Additionally, we reviewed information on VA's mission, functions, structure, employment level, and budget to ascertain if the agency included all of its programs and functions in the evaluation process.

We also reviewed records related to VA's efforts to review its accounting systems. These records included policies and procedures for accounting systems, annual accounting certifications from field facilities, and other documents related to VA's review of its disbursement systems.

To determine how the evaluations were conducted, we interviewed officials in the six major components. We also interviewed officials in OB&F to determine if VA's accounting systems conform to the principles, standards, and related requirements prescribed by the Comptroller General. In addition, we interviewed officials in the OIG, Office of the Associate Deputy Administrator for Information Resources Management, and Management Control Staff to determine how they participated in the process.

VA was given an opportunity to comment on a draft of this report on July 17, 1985, and comments were received on September 6, 1985. (See app. X for detailed agency comments.) Our work was performed in accordance with generally accepted government auditing standards.

CHAPTER 2

UNCORRECTED MATERIAL WEAKNESSES AND NONCONFORMANCE WITH STANDARDS PRECLUDE OVERALL COMPLIANCE

In VA's second annual report (1984), the Administrator of Veterans Affairs stated that VA's system of internal accounting and administrative controls taken as a whole complies with the requirements to provide reasonable assurance that the objectives of the act were achieved. However, VA disclosed material weaknesses that need to be corrected to protect its FY 1985 budget of $26.3 billion (see app. VIII) against fraud, waste, and abuse.

PROGRESS MADE, BUT FURTHER IMPROVEMENT NEEDED

We believe that VA has made progress during the second year in establishing a framework to evaluate and report on the status of its internal controls and accounting systems. VA continues to demonstrate a strong commitment to evaluating and strengthening internal controls. It has revised its internal control directive, finalized guides for conducting preliminary and internal control reviews, and automated its tracking and follow-up system for internal control activities. In addition, VA performed internal control assessments and reviews, increased the involvement of field managers, increased consideration of its ADP controls, and tested disbursements in its six major accounting systems. These efforts resulted in the identification of some material weaknesses in internal controls, and significant areas of nonconformance of its accounting systems with the Comptroller General's principles, standards, and related requirements.

Despite these significant efforts, VA needs to make additional improvements to further strengthen its evaluations of internal controls and accounting systems. To achieve these ends, VA needs to improve the quality of its internal control assessments and reviews, involve greater field participation, and increase consideration of its ADP controls and the testing of its accounting operations.

We recognize that VA has corrected some weaknesses and initiated some corrective actions that will take time to accomplish. We believe that the uncorrected material weaknesses and instances of nonconformance reported by VA, given the limited nature of the evaluation program, further detract from the reliability of VA's reasonable assurance statement. We further believe that VA is not yet in a position to report on whether its accounting systems conform to the Comptroller General's requirements. The problems we found include:

--DVB's regional offices, which administered $15.9 billion in veterans' benefits, or about 62 percent of the agency's budget, did not provide assurance that their internal controls and accounting systems comply with the objectives of the act. (See ch. 5.)

--DVB's review of internal controls over its $3.9 billion pension program was still under departmental review, and DVB had not yet conducted a review of its $10.1 billion compensation program, although major material weaknesses were reported in both programs. (See ch. 4.)

--DM&S did not centrally direct the conduct of any internal control reviews in its $8.6 billion medical care program, and appropriate follow-up actions were not yet completed in such areas as the fee-basis contract hospital program, inpatient drug distribution system, textile care, and Civilian Health and Medical Program of the VA. (See ch. 4.)

--VA did not, for the most part, include in its second annual report plans with specific milestones to correct significant problems and material weaknesses. (See chs. 3 and 4.)

--Two of the major VA departments--DVB and DM&S--did not correct some known major material weaknesses in internal controls and basically reported the same eight material weaknesses VA identified in the first annual report. (See chs. 4 and 7.)

--VA reported that it had ADP problems, particularly the lack of contingency plans to provide reasonable continuity of data processing support should events prevent normal operations and the lack of adequate controls over physical security at its data processing centers. In addition, the agency had not adequately considered ADP controls as part of its internal control assessments and reviews. (See ch. 6.)

--OB&F (Controller), which is responsible for the evaluation of VA's accounting systems, conducted only limited testing of randomly selected disbursement transactions of its accounting systems. In addition, VA reported that it identified instances of nonconformance to the Comptroller General's principles and standards, particularly in the areas of cash management, fund control, and reconciliation/follow-up on accounts in the Loan Guaranty and Centralized Accounting for Local Management systems. (See ch. 7.)

If VA implements our recommendations to correct these problems, noted in chapters 3 through 7 of this report, we believe that VA will have an adequate basis for concluding whether (1) it has reasonable assurance that its internal controls are functioning as they should to prevent fraud, waste, and abuse and (2) its accounting systems conform with the Comptroller General's principles, standards, and related requirements.

AGENCY COMMENTS AND OUR EVALUATION

VA stated that we did not acknowledge the significant improvements and progress the agency made in evaluating internal controls.

We disagree. We pointed out that VA continues to exhibit a strong commitment to evaluating and strengthening internal controls by performing assessments and reviews, correcting weaknesses, increasing the involvement of field managers and the consideration of its ADP controls, and testing disbursements in its six major accounting systems. (See p. 10.)

VA also stated that the basis for our conclusion that the agency does not yet have reasonable assurance is primarily the significant uncorrected weaknesses and instances of nonconformance, and that we failed to give adequate recognition to other available information. Therefore, VA believes that it had an adequate basis to state in its second annual report that its internal control and accounting systems taken as a whole comply with the requirements of the act.

We recognize that management judgment is involved when agencies must decide whether or not their internal control systems provide reasonable assurance that the act's requirements have been met. In deciding this, agencies need to consider four factors collectively:

--The comprehensiveness and quality of the evaluation work performed.

--The significance of the weaknesses disclosed.

--The status of corrective actions.

--The extent to which accounting systems conform to the Comptroller General's requirements.

In our opinion, unless the agency's key accounting systems and internal controls over major programs and functions are adequately evaluated and tested, the agency head does not have an adequate basis to conclude whether the systems taken as a whole provide reasonable assurance. We also believe that, until corrective actions are implemented and tested, the material weaknesses that the actions are intended to address detract from the reliability of a statement of reasonable assurance for the systems as a whole. Evaluations and corrective actions needed to address the act's requirements may take several years to complete. An agency may be making good progress toward that goal, yet not have progressed to the point where reasonable assurance can be provided.

In VA's case, we show in chapters 3 through 7 that significant weaknesses remain uncorrected, internal control assessments and reviews were not adequate, major programs and activities were not reviewed, ADP controls were generally not assessed as part of the assessments and reviews, and the testing of the accounting systems was limited. (See pp. 11 and 12.) These factors, collectively, served as the foundation for our conclusion that VA did not have an adequate basis to determine whether it had reasonable assurance.

Regarding VA's claim that we did not adequately recognize other available information, we agree that alternative sources of information on the effectiveness of internal controls are important and should be considered in determining whether an agency has reasonable assurance. During our review, we considered current OIG and GAO reports, management reviews, assurances given by appropriate agency officials, preliminary GAO findings, size of the organization, diversity of operations, degree of centralization, and the agency's budget. These sources taken together, however, did not substantiate VA's claim that it had reasonable assurance.

We also recognize that VA reached its judgment in accordance with guidelines disseminated by OMB. In our government-wide report[1] on first-year implementation of the act, we recommended that OMB clarify and revise its guidance on what should be contained in the year-end reporting statement. We suggested an approach that would more fully disclose the overall status of controls and material weaknesses. That approach identified functions and operations where (1) controls are adequate, (2) controls are not adequate, and (3) controls have not been sufficiently evaluated to know whether they are adequate. The House Committee on Government Operations, in its August 2, 1984, report on first-year implementation of the act, also recommended that OMB revise its guidance concerning annual reporting. The Committee suggested that it would be more practical for some agencies to report they "have reasonable assurance except . . ." and identify areas where they do not have assurance. However, OMB took no action on these recommendations. We will discuss this issue further in our government-wide report on second-year implementation of the act, to be issued later this year.

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[1] GAO, Implementation of the Federal Managers' Financial Act: First Year (GAO/OCG-84-3, Aug. 24, 1984).

VA also said that we placed undue emphasis on the model process suggested by OMB. The concepts in OMB's guidelines provide a framework for implementing the act, but an agency is not compelled to follow the detailed process if adequate alternative techniques are available. It is more important that the intent of the process--review and testing of systems to identify and correct internal control weaknesses--is achieved. We reported that VA recognized the importance of maintaining effective and efficient field operations and is using long-established systematic management review programs, which appear to be acceptable alternatives, in keeping with the act and the OMB guidelines. (See p. 34.)

With respect to addressing the cost implications of implementing the act at VA, we recognize that the cost of implementing internal controls should not exceed the benefits received. Because benefits and costs are often not precisely quantifiable, many decisions on reasonable assurance necessarily will depend in part on estimates and judgments by management that are reasonable under the circumstances. Therefore, we believe it is VA's responsibility to weigh the benefits of internal controls against implementation costs.

CHAPTER 3

FURTHER IMPROVEMENTS NEEDED IN ASSESSING VULNERABILITY TO FRAUD, WASTE, AND ABUSE

In our first year report on the implementation of FMFIA, we reported that VA's organizational components did not adequately assess their vulnerability to fraud, waste, and abuse. We stated that VA did not sufficiently document its vulnerability assessment findings and results and needed to provide more guidance and training for personnel performing assessments, and we made suggestions to correct these problems. In this year's review of VA's vulnerability assessments, we found that VA had improved its guidance and training, but the problems with vulnerability assessment documentation we noted last year had not been fully resolved.

In addition to reviewing FY 1984 vulnerability assessments, we examined 7 of 25 preliminary reviews, a part of VA's internal control program that we did not review last year because none of these reviews were performed in FY 1983. All seven of the preliminary reviews we examined adequately addressed the internal control problems identified, and five of the seven selected appropriate follow-up actions. Six of the seven reviews were not adequately documented, however; and only one appeared to adequately plan for implementing the follow-up actions.

We found unresolved problems in performing the vulnerability assessments and preliminary reviews, and little assurance that VA organizational components adequately assessed their internal controls in FY 1984. Because of this, we believe that VA lacked an adequate basis to state whether it had reasonable assurance that its internal controls taken as a whole were functioning as they should.

IMPROVEMENT NEEDED IN VULNERABILITY ASSESSMENTS

VA's 346 vulnerability assessments covered all of its organizational components that were required to conduct them in FY 1984, 17 of 22. While VA improved its assessments in terms of guidance and methodology and identified corrective actions for one-third of the 21 assessments we sampled, documentation was not adequate to demonstrate whether programs and functions were vulnerable to fraud, waste, and abuse. Regarding the adequacy of documentation, OMB and VA state that assessments must be properly documented to show that

--the general control environment in which assessable units operate was analyzed;

--the inherent risk potential for waste, loss, unauthorized use, or misappropriation due to the nature of the activity itself was analyzed;

--the adequacy of internal control safeguards over the specific programs and administrative functions being examined within organizational components was evaluated; and

--the results of the vulnerability assessments in terms of the assessable units' adherence to prescribed internal standards and the units' overall vulnerability were summarized.

Four VA components reviewed

In FY 1984, four of the six components selected for our review conducted vulnerability assessments: DM&S, ODM&T, the Office of Procurement and Supply, and the Office of Construction. Of the 346 vulnerability assessments performed overall by VA, 293 were done by those four components. We examined 55 assessments--29 from DM&S, 15 from Office of Construction, 7 from Office of Procurement and Supply, and 4 from ODM&T--for our review of methodology adequacy. Of these, we reviewed 21 assessments--13 from DM&S, 3 from Office of Construction, 4 from Office of Procurement and Supply, and 1 from ODM&T--for adequacy of documentation and what corrective actions were taken.

The criteria for documentation of internal control systems are included as part of the guidelines and standards issued by OMB and the Comptroller General, respectively. The Comptroller General's standard addressing internal control system documentation states that "internal control systems and all transactions and other significant events are to be clearly documented, and the documentation is to be readily available for examination." According to OMB guidelines, the aspects of internal control systems that must be documented are "control objectives and internal control techniques, the accountability for resources, and all transactions and other events . . ."

VA further defines internal control documentation as including written policies, organizational charts, procedures, manuals, flow charts, and completed questionnaires. Documentation also includes related written materials used to describe the internal control methods and measures and to communicate responsibilities and authorities for operating such methods and measures. VA's internal control directive states that such documentation serves as a reference for persons reviewing the internal controls and their functioning.

Our review of the four previously mentioned VA components (DM&S, ODM&T, Office of Procurement and Supply, and Office of Construction) disclosed that only the Office of Construction had documented existing controls that were specific to the activities of assessable units. For instance, in its assessment of the Critical Path Method System (an assessable unit), the Office of Construction identified a risk of construction project schedule errors and documented the following controls to deal with it:

--The system contains a series of analytical and error checking routines to identify errors.

--The initial project schedule is reviewed by the critical path method specialist, the project directors or their representatives, and appropriate technical professionals in the Office of Construction.

--The construction project schedule is reviewed by VA field engineers and critical path method specialists.

All four organizational components addressed to some extent the general control environment as part of the vulnerability assessments, but none except the Office of Construction listed specific controls. Without documentation of specific existing controls, it is difficult for a reviewer to ascertain whether a reasonable determination of a unit's vulnerability has been made.

Vulnerability assessment results not adequately documented

VA's internal control directive requires that assessments include documented evidence of (1) an analysis of the general control environment, (2) an evaluation of inherent risk, (3) a preliminary evaluation of safeguards, and (4) a summary of the assessment results.

Each component we reviewed designed its own form to document the results of the vulnerability assessments. The lack of uniformity in forms may not be a problem in itself, since it allows components to design forms tailored to their needs. However, none of the forms provided for documentation of all information needed in evaluating and reporting on an activity's vulnerability. Each form had documentation shortcomings that detracted from its ability to present a complete picture of the assessable units' vulnerability.

Inadequate documentation of analysis by DM&S

Of 29 DM&S assessments we reviewed, 23 did not provide sufficient documentation of the analysis to support the rating given to the assessable units. Narrative analysis was not required for these 23 assessable units because they were rated of low vulnerability. Only assessable units rated moderately or highly vulnerable were required to have a narrative analysis. Without descriptive and evaluative information on the form, a reviewer who is not knowledgeable about the area being assessed has no way of knowing how the rating was arrived at or whether the vulnerability has been correctly determined.

Inadequate information provided by the Office of Procurement and Supply

The Office of Procurement and Supply's vulnerability assessments did not always provide enough information to show whether existing controls had been reviewed. Although the assessments addressed all four required steps to some extent, four of the seven assessments we reviewed included statements on management and personnel attitudes in the general control environment section. Also, the assessments did not address other control environment factors, such as policies and procedures, organizational checks and balances, etc., which are essential elements to determine the adequacy of internal controls. As a result, a reviewer cannot achieve an understanding of the internal controls that are supposed to be in place and, therefore, cannot assess the reasonableness of the overall vulnerability rating (high, moderate, or low) given to each assessable unit.

Controls and vulnerability not evaluated by the Office of Construction

Of the 15 Office of Construction assessments we reviewed, 13 did not include evaluations of the adequacy of internal controls. The office uses a narrative format that allows for discussion of general control environment and inherent risk factors, but does not provide for an evaluation of safeguards and a summary of results. For example, all assessments list areas of apparent risk and describe some of the controls in place to deal with them. The assessments, however, do not state whether the controls are adequate to deal with the risk, leaving unanswered the question of whether the assessable unit is considered to be vulnerable.

Means to interpret overall degree of vulnerability not provided by ODM&T

For ODM&T's assessable units, the overall degree of vulnerability cannot be determined from the assessments' documentation. The ODM&T form, which contains all steps except the summary of results, uses a system that numerically rates general control environment and inherent risk factors on a scale of 0 to 5. The form also has narrative space for those factors and for problem areas requiring special attention. A separate numerical rating scale is used to evaluate safeguards.

All numerical ratings are totaled on a summary page; however, the overall rating is only specified as a numerical total. Since no key exists on the form for interpreting the total, a reviewer cannot tell how vulnerable the unit has judged itself to be. For example, one assessment received a numerical total of 94; another, 125. No explanation appeared on the forms telling whether these numbers represented high, moderate, or low vulnerability. Without a key to the numerical totals, a reviewer cannot tell the level of vulnerability that has been determined.

SOME CORRECTIVE ACTIONS AS A RESULT OF VULNERABILITY ASSESSMENTS

Corrective actions were reported for 7 of the 21 sample assessments, covering all rating categories (high, moderate, and low). However, in cases where corrective actions were reported, assessors were not always sure that the actions were a direct result of the assessments. For example, one assessor stated that prior reports had pointed out the problem being addressed in one of his assessments, but that FMFIA evaluations were a factor contributing to the action taken.

In all cases where corrective actions were reported, increased or improved monitoring was one of the actions. Two assessors also mentioned that instructions were clarified, and two other assessors reported modifying existing procedures and establishing a training program, respectively.

IMPROVEMENT IN PRELIMINARY REVIEWS NEEDED

Ten of VA's 22 components reported that they performed 25 preliminary reviews in FY 1984. All of the seven preliminary reviews we sampled presented satisfactory analyses of problems or issues of concern and presented corrective actions where appropriate. However, only one of the seven reviews we examined established time frames for implementing corrective actions. In addition, the preliminary reviews of one organizational component were essentially memoranda that did not provide sufficient analysis of concerns to determine whether problems existed. Another component's review briefly listed problems, but did not state possible reasons for their existence.

Preliminary review used to analyze results of vulnerability assessment

To help eliminate unnecessary ICRs and conserve personnel resources, VA developed a preliminary review process based on that developed by the U.S. Department of Housing and Urban Development. As we explained in chapter 1, this process is an intermediate step between vulnerability assessments and ICRs. According to VA's guidelines for preliminary reviews, the preliminary review is a diagnostic process for analyzing the results of vulnerability assessments. Such a review is conducted so that (1) a remedial action plan can be developed to address problems, issues, or concerns highlighted during the vulnerability assessment, or (2) initial planning can begin for conducting a full ICR. The operational responsibility for preliminary reviews rests with each department head and office director.

The preliminary review comprises six steps:

1. Identifying problems, issues, or concerns;
2. Analyzing the problems, issues, or concerns;
3. Analyzing the cause of the problems, issues, or concerns;
4. Selecting actions needed to achieve internal control goals;
5. Planning the actions by determining the party responsible and a time frame for their implementation; and
6. Tracking accomplishment of the actions.

VA's preliminary review guidelines present a reasonable format for identifying and analyzing problems and concerns, and for selecting, implementing, and tracking follow-up actions.

Important steps not always completed in preliminary reviews

Six of the seven preliminary reviews we assessed did not establish time frames for implementing corrective action plans. For example, one DVB review and two Office of Construction reviews analyzed problems and concerns and chose follow-up actions. However, none set forth time frames for taking actions, and two did not discuss parties responsible for the actions. When time frames for action or responsible parties are not mentioned, a reviewer cannot determine when the organizational component will implement the actions discussed in the review.

Three reviews lacked an adequate analysis of concerns being addressed. For example, two Office of Procurement and Supply reviews were little more than memoranda that stated the concerns with no analyses. No corrective action plans were presented, as the programs reviewed by the component were found to have adequate controls, according to the reviews. Due to the small amount of information presented in these reviews, however, we were not able to determine the basis for that conclusion.

Additionally, the DM&S review conducted at the central office that we examined was basically a summary of field reviews and had only summary analyses that did not examine problem causes or show time frames for subsequent actions. Because of this, a reviewer could not achieve a complete understanding of the problems being addressed and could not know if there were definite plans for solving them.

One DVB review completed all steps for the preliminary review. Problems and problem causes were analyzed, actions selected and planned, and a date established for the issuance of a directive implementing the recommendations that centered on improving compliance with existing controls. This last step is important because it indicates that the organizational component that performed the review plans to follow through on its recommendations for solving the problems identified.

CONCLUSIONS

Within the past year, VA published internal control guidelines and performed vulnerability assessments and preliminary reviews. However, the problem of inadequate documentation of vulnerability assessments continued. Also, preliminary reviews were incomplete. Hence, in our opinion, VA cannot be assured that its internal controls are being adequately assessed.

To assist agencies in evaluating their internal controls, OMB devised a process to assess the units' vulnerability. The credibility of this process and its results depend on the degree to which the existing system of controls has been considered, as well as the extent to which the vulnerability assessments have presented sufficient information to accurately evaluate the internal control environment, risks, and safeguards.

To be able to evaluate the vulnerability of their assessable units, assessors need to document the existing system of internal controls. Such documentation can provide a good starting point for current and future vulnerability assessments and serve as a reminder of the controls the assessable unit should be trying to maintain. Once such documentation is on file, information can be updated to reflect any changes that occur from one assessment to the next. The documentation could also provide a basis for ICRs that a unit may need to perform.

Vulnerability assessments need to include better descriptions and analyses of internal controls and clear indications of the level of vulnerability within assessable units. Such information should contribute to more meaningful discussions of possible vulnerabilities and provide more insight as to where improvements or corrections may need to be considered.

VA's preliminary review process seems to be a reasonable step between vulnerability assessments and ICRs. The process offers a means of exploring problems that is less extensive and time-consuming than performing ICRs, which are discussed in chapter 4. The preliminary review process contains six steps we believe should be followed in all cases, so that problems are adequately addressed and promptly acted on (unless the review's analysis indicates no follow-up action needed).

While VA's FY 1984 preliminary reviews were generally reasonable efforts at presenting problems and suggesting follow-up actions, six of the seven preliminary reviews we assessed did not establish time frames for implementing action plans. Additionally, one organizational component's reviews did not present sufficient analysis to support the conclusions they reached. We believe that preliminary reviews should contain sufficient analysis for a reviewer to achieve an understanding of the problems being addressed and enable him/her to reach the same overall conclusion as the assessor.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator of Veterans Affairs require VA departments and offices to

--include in vulnerability assessments (1) an analysis of the general internal control environment, (2) an evaluation of inherent risks, (3) a preliminary evaluation of safeguards, and (4) a summary of the assessment results;

--include in vulnerability assessments documentation of what was assessed and who assessed it, and an analysis of the vulnerability of each assessable unit;

--identify and analyze pertinent problems and concerns during preliminary reviews and select, implement, and track appropriate follow-up actions to correct them; and

--obtain sufficient documentation during preliminary reviews to support the findings and conclusions contained therein.

AGENCY COMMENTS AND OUR EVALUATION

VA shares our concerns for improved documentation of vulnerability assessments but stated that many of the documentation issues result from the fact that the system is new and in developing stages. VA pointed out that the need for improved documentation was addressed in its September 28, 1984, revision to VA Manual MP-1, part II, chapter 15. VA will continue to emphasize this in future contacts with its components. In addition to the revised manual chapter, VA pointed out, a draft vulnerability assessment workbook has been developed to assist VA components in designing and conducting vulnerability assessments.

VA further stated that it believes that vulnerability assessments should not be expected to do more than help determine a level of vulnerability and provide information needed to develop a plan for subsequent actions; therefore, detailed documentation should not be required. We agree that vulnerability assessments should not be a detailed review. We disagree, however, that detailed documentation of assessments should not be maintained. Such documentation would help independent reviewers examine and understand the issues and determine how the conclusions were reached by the original VA reviewer.

CHAPTER 4

FURTHER IMPROVEMENTS NEEDED IN EVALUATING INTERNAL CONTROLS

VA improved its internal control reviews during FY 1984 by providing a reasonable framework for evaluating internal controls. All but one of the ICRs identified control problems, and some managers have begun corrective actions. However, some DM&S' activities rated highly vulnerable were not followed by appropriate actions, and six ICRs did not complete prescribed tasks or lacked an adequate examination of internal controls. In addition, 13 of the 30 recommendations in the pension and education reviews had not been approved for implementation, and tracking of approved corrective actions had not been initiated.

We believe that additional action is needed to ensure that VA's most significant programs and activities are evaluated. ICRs should be strengthened by emphasizing that ICR teams should be adequately trained, complete specified tasks, and adequately document results of reviews. In addition, managers should promptly act on identified control weaknesses.

CRITERIA FOR EVALUATING INTERNAL CONTROLS

An ICR is a detailed examination of internal controls intended to determine whether adequate control measures exist to prevent or detect potential risks in a cost-effective manner. ICRs should be conducted for appropriate programs or administrative functions based on the results of vulnerability assessments, preliminary reviews, and such other considerations as management priorities and resource constraints. Reports on the results of ICRs should recommend corrective actions for any control weaknesses, and managers should consider the recommendations and initiate corrections promptly.

In providing guidance for performing ICRs, OMB recommends the following six-step process:

1. Identify the event cycles.[1]
2. Analyze the general control environment.
3. Document the event cycles.
4. Evaluate the internal controls within event cycles.
5. Test internal controls.
6. Report results.

In providing instructions for conducting ICRs, VA distributed a draft guide to its managers in July 1983. The guide, which generally incorporated the OMB six-step process, with some exceptions, will assist review teams in conducting ICRs. A final version, almost identical to the draft, was issued in September 1984. The guide presents a nine-step approach in which reviewers do the following:

1. Complete the ICR work plan.
2. Identify event cycles.
3. Establish internal control objectives.
4. Select event cycles to be analyzed.
5. Establish standards for control techniques.
6. Test control technique standards.
7. Select corrective actions.
8. Complete an action plan.
9. Track accomplishments.

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[1] OMB defines event cycles as the processes used to initiate and perform related activities, create the necessary documentation, and gather and report data. Each program and administrative function performed in an agency contains one or more event cycles.

Although it incorporates the OMB tasks, VA's ICR guide and internal control directive do not adequately emphasize or clearly present some necessary review procedures. We noted several such instances during our review of ICR documents completed by VA managers in FY 1984.

Procedures in the review of internal controls that need further clarification include:

--Specifying training needs of ICR team members. The VA internal control directive requires components to provide employees training necessary to accomplish internal control duties. However, the ICR guide does not mention training, and none of the review team members we spoke with had received any formal training on the ICR process, although one team had obtained technical assistance from the OIG. Several members said that training on the ICR process and documentation of review activities would have helped them in conducting the ICRs.

--Specifying that the nine steps in the VA guide must be completed. Instructions state that ICR teams may modify the process, but do not indicate that they must still complete each review step. ICRs we reviewed that used the VA instructions did not always include all the steps. For example, one ICR team did not complete some key worksheets and did not otherwise document the tasks involved.

--Requiring managers to address ICR recommendations by specifying time frames for resolving problems identified in ICRs. As noted on page 30 of this report, management had not specified actions on 12 of 14 recommendations in one ICR after the report was issued. Moreover, the VA guide suggests that ICR teams should prepare corrective action plans, specifying expected completion dates and persons responsible for the actions. ICRs we reviewed included little such information, and we believe that such plans may more appropriately be completed by managers rather than review teams.

ICRs IMPROVED, BUT DID NOT FULLY EVALUATE CONTROL SYSTEMS

ICRs conducted by VA during FY 1984 generally were more complete than FY 1983 reviews. Reports on the ICRs provided evidence that in FY 1984 prescribed review tasks were more often completed and included activities that disbursed significant moneys. These ICRs included major VA activities, such as the pension benefit program ($3.9 billion), education benefit program ($1.5 billion), and payment systems for employee payroll ($6 billion), vendors ($2.7 billion), and construction contractors ($436 million). A list of the ICRs appears in appendix V.

Although ICRs were improved in FY 1984, most still did not consider internal control objectives and techniques in sufficient detail to ensure that all internal control problems were identified. In addition, several ICRs excluded significant segments of the activity being reviewed and DM&S, which has an annual budget of about $8.6 billion, did not centrally conduct any ICRs, because it was in the process of conducting vulnerability assessments to plan for future ICRs.

We analyzed 10 review reports and discussed several with ICR team members. We studied two of these reports in more depth by contacting all team members, reviewing ICR documentation, and discussing review results and corrective actions with both central office officials and managers at three regional offices. We selected DVB's reviews of the pension and education programs for this in-depth study, because both are costly programs in which VA identified material weaknesses during 1983.

Of major activities rated highly vulnerable, some not reviewed

Most VA components, 15 of 22, did not conduct ICRs during FY 1984, including those which identified highly vulnerable areas in their operations. For example, DM&S had not conducted any ICRs, although it had rated 12 of its 252 assessable units as highly vulnerable. DM&S operations in FY 1984 cost $8.6 billion--about a third of VA's total budget. The department has scheduled three ICRs for FY 1985, including two that would examine controls over nonappropriated funds.

In addition, the ICRs that VA completed sometimes did not evaluate important segments of the activities being reviewed. For example, the pension and education program ICRs largely excluded complex ADP systems used to process benefit payments. ICRs of the payroll, vendor, and construction-contractor payment systems were limited to data processing center operations, and evaluation of payment processing controls at other VA offices was limited to a review of the accuracy of sample transactions.

Sufficient evaluation and documentation still lacking

Our analysis of 10 reports on ICRs conducted during FY 1984 indicated that they were more complete than those conducted in FY 1983. As we reported last year, 14 of the 16 reviews in FY 1983 did not evaluate or test controls and provided little information on conclusions or planned actions. This year, 6 of the 10 ICRs covered most of the OMB steps to some extent, and 8 included some evaluation of internal controls.

We compared work done by each ICR team to the OMB-prescribed tasks, noting the number of ICRs that included each task, as follows:

--Identification of event cycles (6)
--General control analysis (8)
--Documentation of event cycles (6)
--Evaluation of internal controls (8)
--Testing of internal controls (8)
--Reporting of results (10)

Six of the reviews by OB&F were limited in scope, examining particular aspects of payment systems. These reviews reached conclusions, but we were sometimes unable to judge their adequacy due to their limited discussions of event cycles and control environments. Two reviews by ODM&T omitted numerous prescribed review tasks such as identification of event cycles and documentation of event cycles. Our more detailed analysis of the remaining two ICRs, both by DVB, follows.

Sufficient evaluation and documentation lacking in DVB reviews

Even when ICRs included the prescribed tasks, they were not always detailed examinations that would identify all control problems. In our in-depth study of ICRs on the pension and education programs, we found that ICR teams established objectives and techniques that were too general; as a result, 26 of the 30 recommendations were not developed from an evaluation of the control systems.

DVB devoted significant resources to both the pension and education reviews. Six managers and program specialists, including two from regional offices, were assigned to each team for about 6 weeks. Both teams visited two regional offices to observe operations, interview employees, and test controls. The pension team visited a third field site to assess a centralized process that annually determines the continuing eligibility of pensioners. Resulting reports included 30 recommendations to improve internal control systems.

Our analyses of the reviews indicated that the review teams documented general control objectives[2] but not specific objectives tailored to the programs. For example, a general control objective of 99 percent accuracy in benefit payments was stated for three of the four event cycles used in the pension review. Specific control objectives, such as pension benefits being paid only to veterans with at least 90 days of wartime military service, were not documented.

Control techniques[3] were documented in a similar manner, but were not described in enough detail to show a direct link to control objectives. For example, an objective in the education review was to accurately verify dependency 97 percent of the time. Related control techniques included supervisory reviews and performance evaluations. Documentation of the ICRs, however, did not include (1) a description of the reviews being conducted or how evaluations were related to the objective and (2) an explanation of how they ensured that the objective was achieved.

Moreover, in our analysis of documentation and discussions with team members, we found that all 14 of the pension ICR recommendations were not developed by evaluating control objectives and techniques. Rather, they were often derived from other studies or based on experiences of team members. Pension team members said their recommendations were selected before any testing was conducted and testing was directed to support the recommendations rather than to determine whether techniques were effective. All 14 pension recommendations had been discussed in earlier studies. While it is appropriate to include such recommendations, additional control problems might have been identified if the teams had compiled and linked detailed control objectives and techniques.

When discussing recommendations with us, members of both ICR teams referred to their experiences that were not included in review documentation. Teams also sometimes did not document interviews or tests nor retain narrative descriptions or flow charts of event cycles. As a result, documentation did not always adequately support recommendations or allow an independent reviewer to determine how conclusions were reached.

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[2] OMB defines control objectives as desired goals or conditions for an event cycle that reflect the application of overall objectives of internal control to that cycle.

[3] OMB defines control techniques as the processes or documents that enable control objectives to be achieved.

In our opinion, these problems were partially due to the large programs that teams were asked to review in relatively short time frames. Several team members said that review scopes were too large, and some said that this caused the use of broad objectives and frequent reliance on prior studies and experiences of team members.

ICR RECOMMENDATIONS DID NOT ALWAYS RESULT IN CORRECTIVE ACTIONS

VA is addressing many of the internal control problems identified by ICRs. Its tracking system for internal control activities indicated that several corrective actions had been completed by the end of 1984. However, 13 of the 30 recommendations in the pension and education ICRs had not been approved for implementation, and approved corrective actions had not been tracked.

In our study of the pension and education ICRs, we found that, while DVB managers were working to correct many control problems, most recommendations had not been implemented. Managers had not specified actions to be taken on some problems noted by the pension review. Also, in some ICRs, conclusions and recommendations did not include detailed information that would allow managers to correct or improve specific controls.

No management action planned on some recommendations

VA managers placed ICRs and resulting corrective actions in their tracking system. In some cases, however, managers had not identified what actions would be taken on recommendations or when actions would be completed. For example, as of January 1985, the Chief Benefits Director had not started corrective actions for 12 of the 14 recommendations in the pension ICR, and 2 actions that had been identified were simply noted in the tracking system to be long-term projects. Similarly, the system indicated no anticipated completion date for plans still being developed to address 12 recommendations in an ODM&T review of ADP security. Several OB&F actions also lacked such dates.

Moreover, components generally did not prepare written plans for corrective actions. The VA internal control directive requires written plans that include the person responsible for the actions, anticipated completion dates, a description of the scope and rationale for the action, and required staffing and other resources.

DVB actions underway on most recommendations

DVB managers had begun, but not fully implemented, corrective actions on 19 of the 30 recommendations in the pension and education ICRs. The then-Chief Benefits Director had approved 15 of 16 education program recommendations, and program managers had begun corrective action on each. No management decision had been issued on 12 of the 14 pension recommendations; however, some actions had been taken on several because most of the problems involved had been identified in earlier studies. Plans were underway on the two approved pension recommendations, which involved major changes in the annual eligibility review of pensioners.

Few recommendations, however, had been fully implemented as of January 1985. In the education program, central office officials said that they had developed corrective actions and issued necessary directives on 10 of the 15 ICR recommendations. However, managers at three regional offices, Chicago, Milwaukee, and Indianapolis, had not received some directives on control changes or had not implemented them. For example, 2 months after the central office directed regional offices to insert instructional messages into computer systems to remind employees of a necessary manual processing step, only one office had done so. Similarly, the three regional offices had misinterpreted new requirements for monthly reports on delays in entering initial control information on pension applications into the computer system and had not submitted reports. A central office official said that other offices also failed to report delays.

According to DVB officials, regional office implementation of control system changes is verified during periodic inspection visits by central office staff, generally every 1 to 3 years, and by exception reports required by directives on some control changes.

ICR conclusions and recommendations not specific

Some reports we reviewed did not identify specific control problems nor recommend actions that would correct or improve them. Conclusions and recommendations were sometimes too general and, in a few cases, were not included in reports.

Examples in the ICRs we reviewed included:

--An ICR on subsidiary accounts in the vendor payment system mentioned several problems with reconciliation of subsidiary accounts and outstanding obligations. However, no overall conclusion on control problems was presented, and the report recommended only that field offices should be notified of the importance of these activities.

--One of the 14 recommendations in the pension review suggested that VA develop the potential of the program's computer system as an internal control. Although the recommendation mentioned assignment of personnel to monitor computer system changes and automated data exchanges with other organizations, it referred to no specific control objectives or techniques.

CONCLUSIONS

Although VA improved its framework for conducting ICRs in FY 1984, we believe that additional action is needed to ensure that ICRs evaluate the most significant programs and activities. During the year, VA published a guide that assists managers in conducting ICRs, and agency components reported a number of ICRs that more adequately evaluated internal controls than did earlier reviews.

The guide, combined with the agency's internal control directive, covers review tasks prescribed by OMB. With added emphasis on a few review procedures (see p. 22 of this report), it will give VA managers an adequate methodology for evaluating internal controls. In our review of the ICRs, however, we found that review teams did not always complete the necessary review tasks nor adequately document the results of the reviews. As a result, some reviews did not adequately address significant programs and activities nor document the review process.

Some activities judged by VA to be highly vulnerable, most notably in DM&S, were not reviewed in FY 1984. In activities reviewed, VA components did not track some approved corrective actions, and managers did not always act to correct control weaknesses identified by ICRs.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator of Veterans Affairs require VA departments and offices to

--provide training to ICR team members on the internal control review process, including documentation requirements,

--fully comply with the agency's nine-step approach for conducting ICRs, and

--implement corrective actions recommended by ICRs and track the actions to determine whether internal controls were strengthened.

AGENCY COMMENTS AND OUR EVALUATION

VA agrees with the intent of our recommendations and recognizes that adequate documentation of actions following vulnerability assessments is necessary. VA believes, however, that we placed too much emphasis on conducting ICRs that follow a model process rather than the broad range of possible actions that may be appropriate. We believe that the OMB concept of internal control reviews is sound but that the detailed approach need not be the same for all VA programs and activities. Other variations of the internal control review process defined in the OMB guidelines will undoubtedly emerge as VA gains experience in completing this type of evaluation. Alternatives, such as VA's long-established systematic management review programs and inspections performed by VA or its contractors, appear to be acceptable alternatives for meeting the requirements of the act.

VA also noted that DM&S provided training on OMB circular A-123 requirements to both central office and field personnel during FY 1984. It further stated that training included the nine-step approach involved in the internal review process.

In addition, VA commented that the preliminary review and ICR guidelines that the agency published are intended to be training instruments that provide review teams with a model process, but each team must decide whether or not the model is the best approach. VA believes that, rather than train ICR teams in a fixed approach, it should provide broad-based training that encompasses determining the best course of action. We believe such an approach is reasonable.

VA also commented that, to improve the tracking system and ensure that appropriate corrective actions are implemented, it has modified its "master calendar," which summarizes internal control activities. VA further pointed out that corrective action tracking and follow-up are accomplished through DM&S' Systematic External Review Program.

CHAPTER 5

FIELD PARTICIPATION IN INTERNAL CONTROL

EVALUATIONS INCREASED, BUT IMPROVEMENTS NEEDED

VA increased field participation in the internal control evaluation process in FY 1984. As noted in our first-year report, although VA had components such as DVB and DM&S with numerous facilities located throughout the country, it had not always obtained input from these field activities for the FY 1983 evaluations. As a result of our report, VA agreed to include more field activities in its internal control evaluations. During FY 1984, DM&S medical centers completed numerous internal control evaluations; however, DVB regional offices were not required to conduct such evaluations until FY 1985.

Because field facilities--regional offices and independently operated medical centers--expended over 95 percent of VA's FY 1984 appropriations of $25.7 billion, effective and efficient internal control systems at the field level are crucial. VA, recognizing the importance of effective and efficient field operations, has in place long-established systematic management review programs to assist field managers in evaluating their operations on an ongoing basis.

But, because the management review programs and those internal control evaluations conducted did not adequately assess internal controls at VA field facilities during FY 1984, evaluations of such controls need improvement. We found the following shortcomings in these evaluations:

- --Regional offices were not required to, and generally did not, conduct internal control evaluations during FY 1984;
- --Medical center internal control evaluations were not conducted in a consistent manner among hospitals (two did vulnerability assessments; four did reviews of internal controls);
- --Internal controls for some crucial operations, such as property management, were not evaluated;
- --Management review programs generally did not consider internal controls; and
- --Field managers were not adequately trained to conduct internal control evaluations.

Tracking and follow-up systems to address identified problems generally were inadequate. Field facilities did have systems, but these generally were informal and decentralized, and did not ensure that identified problems were promptly corrected.

VA PROGRAM APPROPRIATIONS SPENT MOSTLY BY FIELD FACILITIES

The Congress appropriated $25.7 billion to fund benefits and services administered by VA in FY 1984. Of this total, over 95 percent was for benefit and medical programs administered by field facilities. For example, compensation and pension benefits totaling $14.1 billion were appropriated to benefit some 4.2 million veterans and their survivors. More than $8.6 billion was appropriated for medical care and treatment provided to over 1.4 million inpatients and for 18.6 million outpatient care visits. Appropriations of over $1.5 billion were made for readjustment benefits that provided education and training to almost 600,000 beneficiaries.

In addition to appropriated funds, VA operated the nation's fifth largest individual life insurance program, under which the agency administered or supervised about $146 billion in coverage. Nine programs supervised by VA but administered by private companies provided insurance coverage to 7.4 million service personnel and veterans.

VA activities are administered by a network of field facilities that provide services to eligible recipients. For instance, VA operates 172 hospitals, 226 outpatient clinics, 16 domiciliaries, 58 regional offices (including 2 insurance centers), and numerous other field facilities (supply depots, data processing centers, and national cemetery area offices). These facilities are located in every state, the District of Columbia, Puerto Rico, and the Philippines. Together, the VA field facilities employ about 235,000 persons--about 98 percent of all VA employees. (See app. IX for further details.)

FIELD FACILITIES DID NOT ADEQUATELY ASSESS INTERNAL CONTROLS

Until FY 1985, the regional offices were not required to conduct internal control evaluations, thus crucial regional office activities were not evaluated. Also, existing management review programs did not adequately consider internal controls. Medical centers and regional offices constitute the vast majority of VA field activities, responsible for administering a major share of the moneys. Both types of facilities operated management review systems to evaluate operations before the advent of FMFIA, but we found that these existing systems did not provide an adequate evaluation of internal controls. Although medical centers were instructed by VA's central office to implement a supplementary internal control evaluation system, this system was too limited in scope and did not adequately evaluate internal controls.

Regional office internal control evaluations not required

Internal control evaluations were not required at regional offices during FY 1984 nor, except for isolated instances, were they performed. On July 5, 1984, DVB issued circular 20-84-20, which provided for supplementary reviews of internal controls at regional offices, but the circular was not required to be implemented until September 1, 1984. As a result, the actual reviews generally were not begun until FY 1985. However, the Philadelphia and Chicago regional offices did conduct during FY 1984 several of the reviews provided for in the circular.

Medical center internal control evaluations not conducted consistently

Internal control evaluations were required at each medical center during FY 1984, but confusion in the instructions for conducting the evaluations led to inconsistent efforts. DM&S issued circular 10-83-100 on July 5, 1983, to implement reviews of internal controls performed during FY 1984. The circular identified 41 areas as being highly vulnerable to fraud, waste, and abuse, and required that ICRs be undertaken. Subsequently, a June 1984 conference call from VA central office to medical centers changed the requirement from that of doing ICRs to one of doing vulnerability assessments. DM&S central office officials told us that, realizing some field facilities were confused, they wanted to ensure vulnerability assessments were done before ICRs.

We found that two of the six medical centers we visited followed the original guidance, two followed the revised instructions, and two tried to do both, as detailed below:

--The Philadelphia and Ann Arbor centers followed the original guidance and focused exclusively on reviewing internal controls of the 41 areas identified in the circular. The reviews generally followed local hospital guidance, however; as a result, the evaluations at these facilities varied as to quality and generally were not done in the depth that would have resulted in adequate evaluations of internal controls.

--The Coatesville and Kerrville centers followed the revised guidance and focused on vulnerability assessments of the areas identified in the circular. For instance, the Coatesville center scheduled 61 areas for assessment, of which 29 were required by the circular and 32 were locally identified. Kerrville performed 64 vulnerability assessments, 24 of them done under the 1984 circular.

--The Danville and Marlin centers tried to complete both vulnerability assessments and reviews of internal controls of the identified areas. At Danville, many assessments were not adequately documented, and we could not verify that the limited reviews of internal controls were adequate. Marlin completed 25 vulnerability assessments and limited reviews of internal controls.

The confusion and inconsistency of effort among these centers reduced the effectiveness of the overall DM&S effort and the confidence that can be placed in the results.

Some crucial operations not evaluated

Existing management review programs and internal control evaluations conducted did not evaluate all crucial operations at field facilities during FY 1984. Property management, receipt of cash and negotiable instruments, and facility security and law enforcement were among the crucial areas of operations identified by DVB circular 20-84-20 and DM&S circular 10-83-100 to be reviewed as part of the evaluations of internal controls.

To determine the degree of coverage achieved during the year, we compared the crucial areas of field operations identified in the two circulars with the areas actually reviewed.

Field facilities utilized a number of control techniques under the existing review processes to measure operations, but two primary ones were used at each type of facility. Regional offices used:

--The Statistical Quality Control process evaluated work quality through identifying error tolerance rates, sampling work units for quality evaluation, and measuring the results against the rates.

--The Systematic Analysis of Operations process provided information on performance in relation to established standards; performance not subject to formal control and measurement; effectiveness of control systems and other management processes; reliability of performance data submitted in recurring reports; and improvement potential.

Medical centers utilized an existing two-step review process:

--The Systematic Internal Review was a facility-based system for monitoring and controlling operations.

--The Systematic External Review Process provided for periodic site visits by multidisciplinary peer review teams to evaluate each facility's management review program.

The Philadelphia regional office reviewed 84 percent (57 out of 68) of its applicable crucial operations during FY 1984, and the Wilmington regional office reviewed 34 percent (12 out of 35) of its crucial operations. The Wilmington office had fewer applicable reviews primarily because it did not have a Loan Guaranty Division. Crucial operations not reviewed by Philadelphia included such subjects as staffing and employee utilization, suspended credit records, debt collection referral, and claims processing. Examples of areas not reviewed by Wilmington were: use of government motor vehicles, property management, monitoring of education overpayments, and veterans' work-study contracts.

The Philadelphia medical center evaluated 89 percent (32 out of 36) of its crucial operations, and the Coatesville medical center evaluated 68 percent (21 out of 31) of its relevant operations. The four assessments not done by Philadelphia were: station fund control, home oxygen, quality control in research and development, and research and development reporting requirements. Examples of areas not reviewed by Coatesville were: textile care, accuracy of generated payments, ambulatory care pharmacy, and control of precious metals.

Internal controls not explicitly considered

In its response to our report last year, VA said that field facilities had long-established systematic management review programs that already met many of the requirements for internal control evaluations. We found that the existing management review programs were designed for various purposes and did not generally focus on internal controls. The regional office management review programs were more attuned to testing output to evaluate quality and operational effectiveness. Medical center management review programs were designed to evaluate several items, such as the effective utilization of resources.

Existing management review programs and internal control evaluations in the regional offices were oriented to identifying problems with operations. Although they did not specifically evaluate internal controls, these were sometimes mentioned as being a problem. For example, the DVB circular requires the Finance Division to review semiannually all cash salary payments processed during the preceding 6 months. If, in more than two instances, cash salary payments were not made as authorized, there exists a material internal control weakness that should be reported to the regional director. The Chicago regional office considered internal controls in 22 of 26 management review programs that we reviewed. In other instances, we noted that when a problem was identified through one of the existing review processes, a "person failure" was assumed to be the cause of the problem without consideration of possible internal control inadequacies.

Existing management review programs and internal control evaluations at medical centers did not specifically focus on internal controls. One reason was that the implementing circular directed that the internal control evaluations be incorporated into the facility's management review program, and no further guidance was given as to how to evaluate internal controls. Thus, we found that reviews that purported to be evaluations of internal controls generally followed the local management review program. In our opinion, local guidance generally proved to be ineffective to use in evaluating internal controls.

The management review program coordinator at Philadelphia confirmed that internal control evaluations contained basically the same elements as the management review program. Our work at the Ann Arbor center revealed that the management review program sometimes identified internal control problems, such as lax equipment security, improper use of prescription forms, and failure to confirm the recording of personnel terminations in the payroll system. With the exception of the Financial Services, however, we saw no instructions on conducting management review programs.

Managers not adequately trained

For the most part, formal training was not given to managers primarily responsible for conducting internal control evaluations. Training can help managers to better understand the largely unfamiliar concepts of FMFIA. In its "Questions and Answers on Circular A-123 (revised)," OMB stated that training in performing vulnerability assessments and internal control reviews and on reporting the results should be provided to managers and other agency staff. The OMB document further stated that programs should be centrally directed to underscore the importance of internal controls and to help assure a more reliable product upon which to base future actions.

As DVB did not have a training program, regional office managers were not formally trained in the importance and objectives of internal control evaluations nor in the proper procedures for conducting them. DVB did not design nor implement a centrally directed training course for managers responsible for internal control evaluation. The Director of DVB's Management and Manpower Staff stated that field managers are experienced in the areas to be evaluated.

At the Philadelphia regional office, we were told that the Regional Director discussed the internal control evaluations with division directors during meetings. We did not, however, find evidence that directors conducted training for their managers.

At the Chicago regional office, we found that the internal control officer had discussed internal control evaluations with division chiefs. The Finance Officer at the Houston regional office and the Assistant Director at the Waco regional office said that they had not received any training on internal controls nor their evaluations. We believe that training is necessary to ensure that internal control evaluations are done in a consistent manner.

Program coordinators for medical center management reviews were trained by DM&S central office personnel, but field managers responsible for performing internal control evaluations generally were not. A DM&S training course for local coordinators was presented during FY 1984 at the various Regional Medical Education Centers. Coordinators then returned to their centers and conducted training classes for their directors and managers.

Philadelphia's management review program coordinator said that he was disappointed with the local training because it did not give managers clear guidance as to what was to be done. On the other hand, the Coatesville center officials said that the course met the objectives and that their understanding was greatly enhanced. Management review program coordinators at Danville and Ann Arbor said that more guidance was needed in three areas: integration of the internal control evaluation process into the management review program, segmentation of services into key functions, and conduct of ICRs.

NEED TO ESTABLISH TRACKING AND FOLLOW-UP SYSTEM AT EACH FIELD FACILITY

A tracking and follow-up system is important because the purpose of FMFIA can only be accomplished if appropriate and timely corrective actions are taken on all known weaknesses in internal controls. VA regional offices and medical centers generally lacked a formal cohesive tracking and follow-up system to ensure that identified problems were corrected on a timely basis. Rather, each facility relied on a variety of informal tracking systems.

OMB circular A-123 (revised), which implements FMFIA, states that a formal follow-up system should be established to record and track recommendations, project action dates, and monitor whether changes are made as scheduled. OMB guidelines provide that follow-up systems should also identify the person responsible for taking the corrective action. The guidelines further provide that problems identified through other means are to be considered by management in making its yearly assessment of the condition of its internal controls. Follow-up systems should include not only problems identified through the internal control review processes, but also through other processes, such as GAO or OIG reports and management studies.

During our visits to the Danville and Ann Arbor centers, we noted that internal control weaknesses had been identified by the Joint Commission on Accreditation of Hospitals and the OIG that were not tracked and were not included in the informal tracking systems. The OIG had reported 46 internal control "exceptions" at the two centers and their outpatient clinics.

Regional offices used a variety of approaches to track identified problems, but generally did not utilize formal, centralized systems. For example, at the Wilmington office, reports were submitted to the Associate Director for review and comment. The Associate Director then returned the report to the appropriate division chief with comments either concurring with, or disagreeing with, the findings and recommendations.

The Philadelphia office required division chiefs to report to the Director "out-of-line situations," which were then discussed during a quarterly briefing. The division chiefs maintained documentation of the review and of any corrective action. Management analysts in the Director's office were to follow up on required corrective actions, but there was no assurance that this action was accomplished.

The Chicago office used a similar system in which management analysts were to follow up on review schedules and corrective actions. Corrective actions were usually identified when a report was made, analysts said, and tracked to later verify corrective actions. Verification was usually informal and not documented. As in Philadelphia, division chiefs were required to include problems in quarterly reports and discuss them with the Director.

The Houston and Waco offices lacked formal systems for monitoring internal control activities, but used quarterly briefings to bring problems to management's attention. Any uncorrected problems were to be monitored by the Assistant Director. The Houston office is to address follow-up of recommendations and corrective actions in a proposed local circular on internal controls, systematic analysis, and "out-of-line situations."

Medical centers employed a number of methods to follow up on identified problems, but these tended to be decentralized among hospital services. For example, service chiefs at the Philadelphia center were responsible for monitoring and assuring the implementation of corrective actions. The service chiefs lacked standard guidelines, we were told by the management review program coordinator, but each service did have a system. The chiefs of fiscal, supply, and surgical service each said that no formal system was used and each used various informal methods, such as assigning responsibility to a supervisor to ensure corrective actions were accomplished.

A similar system existed at the Coatesville center where there was no standard policy, but each service chief was responsible for assuring that deficiencies were resolved. The service chiefs were required to report quarterly to the Director on these activities and meet with him semiannually. The chiefs of supply and fiscal service confirmed that no formal system was used to monitor corrective actions, but section chiefs were usually assigned responsibility for seeing that specific actions were implemented.

The Danville center required service chiefs to submit quarterly reports, but the management review program staff told us that they had not followed up to ensure that corrective actions were implemented. At the Ann Arbor center, the management review program coordinator told us that service chiefs were telephoned quarterly to determine the status of corrective actions. The internal control review coordinator at the Kerrville center and the management review program coordinator at the Marlin center both said no formal tracking and follow-up system existed, but that they monitored the status of activities through annual briefings with the Director and quarterly reports to the VA central office.

CONCLUSIONS

Effective internal control evaluations at VA field facilities are important to the achievement of FMFIA's objectives because most resources appropriated by the Congress to operate VA programs are expended primarily at the field level. VA field facilities did not assess internal controls during FY 1984 in a manner that would provide a high degree of assurance as to the adequacy of the internal controls. The existing management review programs at the regional offices and medical centers and internal control evaluations had a number of shortcomings. In addition, regional offices were not required to conduct internal control evaluations during FY 1984, thus major activities were not evaluated. Medical centers did not carry out a consistent evaluation program in that two of the six centers we visited did vulnerability assessments while others attempted to do ICRs for which they had inadequate guidance. Some crucial operations were not reviewed at regional offices and medical centers; reviews that were done generally did not explicitly consider internal controls; and managers responsible for the reviews were not adequately trained.

Generally, VA field facilities lacked assurance that identified problems were corrected on a timely basis, because formal, centralized tracking and follow-up systems were not in place. Such systems are required by OMB circular A-123 (revised) and should contain problems identified by various sources, such as from internal control evaluations, GAO and OIG reports, and management studies. Follow-up systems should log and track all planned corrective actions and identify responsible persons and target dates. Currently, field activities use follow-up systems that do not meet one or more of these criteria. Since regional and medical center directors are required to submit annual assurance letters, we believe that those officials need systems that incorporate those criteria.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator of Veterans Affairs direct

--the Chief Benefits Director to require regional offices to analyze the sources of problems revealed by the reviews required by DVB circular 20-84-20 and other processes,

--the Chief Benefits Director and the Chief Medical Director to require that each field facility implement a formal, centralized tracking and follow-up system that addresses internal control weaknesses identified by any source, and

--the Chief Benefits Director to require regional offices to train managers who are responsible for internal control evaluations.

AGENCY COMMENTS

VA concurs with our recommendations and stated that DVB issued circular 20-84-20 on July 5, 1984, to bring its regional offices into the internal control process. VA pointed out that, since regional office directors could not be expected to provide well-documented statements of written assurance in the approximately 2-1/2 months then remaining in FY 1984, the DVB circular did not require the statements of assurance until the end of FY 1985. VA also commented that DM&S currently requires medical centers to establish a formalized tracking and follow-up system within the Systematic Internal Review Process.

CHAPTER 6

EVALUATION OF ADP INTERNAL CONTROLS:

PROGRESS MADE, BUT MORE IMPROVEMENTS NEEDED

VA made progress in evaluating automated data processing controls in FY 1984, but additional improvements are needed to ensure consistent and comprehensive coverage. We found that vulnerability assessments inconsistently evaluated ADP-assessable units and did not consider the adequacy of ADP internal controls at VA medical centers. In addition, our examination of VA's internal control review of its $3.9 billion pension program disclosed that VA did not fully recognize the program's vulnerability to known systems and internal control weaknesses. More specific guidance for conducting ADP internal control evaluations would enhance ADP coverage, we believe, and contribute to more consistent, complete evaluations of ADP controls throughout VA.

QUALITY OF VA SERVICE LARGELY DEPENDENT ON ADP

Providing prompt service to the veteran is VA's primary responsibility in administering its benefit payment and health care delivery programs. The quality of that service depends largely on how well the ADP systems function in supporting VA's daily operations. Essentially all of VA's major programs are supported by computers. For example:

--DVB uses computers to account for and control $15.9 billion annually in benefit and assistance payments.

--DM&S uses computers to support VA's $8.6 billion nationwide medical care system for providing health care to veterans.

To support its programs, VA operates over 700 computers located at its 5 agency-wide data processing centers and at all but 3 of its 172 hospitals.

The Associate Deputy Administrator for Information Resources Management is responsible for overseeing VA ADP resources. ODM&T, which is responsible for much of VA's ADP operations, reports to him. There are, however, exceptions. For instance, DM&S has been assigned the direct responsibility for the management and control of the Decentralized Hospital Computer Program at VA medical centers.

Currently, ODM&T (1) operates the five VA-wide data processing centers, (2) provides ADP support--automated application systems and computer equipment--to the staff offices at VA's central office and the Departments of Veterans Benefits and Memorial Affairs, (3) manages ADP system development and equipment procurement projects for the VA organizational components it supports, and (4) coordinates most acquisitions for ADP hardware, software, and support services. Additionally, DM&S (1) operates computers at 169 of its hospitals, (2) provides ADP support for medical programs and operations, and (3) manages ADP system development and equipment procurement projects to support medical programs and operations.

Because of ADP's importance to its programs, VA needs to thoroughly evaluate ADP internal controls. OMB's August 1984 questions-and-answers guidebook states that managers should assure that proper controls are in place in ADP operations and system applications and, when conducting internal control evaluations, verify that such controls are working. ADP internal controls can be divided into two major categories--general controls and application controls:

--General controls are controls applicable to all the processing carried out by an ADP center. For example, some general controls include the plan of organization and operation of the ADP activity; the procedures for documenting, reviewing, testing, and approving systems or programs and program changes; disaster recovery procedures; access to equipment and data files; and independent reviews of ADP activities. Effective general controls are necessary for achieving reliability and security over the data processing by the ADP center.

--Application controls are controls related to specific computer applications. Application controls often are categorized as data origination, input, processing, and output controls. Origination controls assure that source documents are authorized, complete, accurate, properly accounted for, and transmitted in a timely manner for input into the computer systems. Input controls assure that data have been properly authorized and converted into machine readable form and that the data have not been lost, suppressed, added to, duplicated, or otherwise improperly changed. Processing controls assure that complete and accurate information is processed by the computer application programs from data entry to output. Output controls are designed to ensure the accuracy of the processing results and to ensure that only authorized personnel receive the output.

ADP managers are usually responsible for evaluating general controls. Program managers, however, are usually responsible for evaluating application controls.

MORE SPECIFIC GUIDANCE NEEDED FOR EVALUATING ADP CONTROLS

VA's internal control directive did not provide specific instructions for evaluating ADP controls. As a result, VA's assessments of ADP-assessable units did not consistently evaluate ADP controls or consider the adequacy of such controls throughout VA. Also, our review of VA's $3.9 billion pension program showed that VA did not recognize the program's susceptibility to significant ADP systems and internal control weaknesses.

ODM&T and DM&S conducted vulnerability assessments of 34 ADP-related assessable units. Seven of VA's 22 components conducted 14 ICRs, which included two by ODM&T, of activities dependent on computer processed information. Of these control evaluations, we selected 19 assessments and one ICR for our review. Of the assessments selected, 5 were conducted by ODM&T and 14 by DM&S. The ICR selected was conducted by DVB.

Our review showed that ODM&T, in its evaluation of internal controls, generally included assessments of ADP controls. However, we noted inconsistencies in the quality of its assessments. As for DM&S, we found it did not assess ADP controls at VA medical centers. Finally, we found that the review of the pension program did not evaluate significant application controls or obtain assurance of the adequacy of ADP general controls or recognize the effects of known significant control weaknesses on the current administration of the program.

Improvements needed in vulnerability assessments

Both ODM&T and DM&S identified ADP functions as assessable units, conducted vulnerability assessments of these units, and identified some control weaknesses. However, we believe that additional weaknesses might have surfaced had ODM&T assessments been conducted consistently and DM&S assessments involved field office personnel.

ADP internal controls generally considered in ODM&T assessments

We found that ODM&T generally did a good job of evaluating its ADP internal controls even though some of its assessments were done inconsistently. ODM&T identified 18 assessable units to evaluate and further subdivided these for evaluation purposes. ODM&T designated each of the five agency-wide data processing centers and the telecommunications services as primary units. Each center and service then identified as subunits such well-defined functions as systems maintenance and development, application software control, computer operations, and physical security. Of the 18 primary units, we selected for review VA's 5 data processing centers, which included 39 subunits. We selected these assessments because of the high concentration of ADP systems and equipment resources at the data processing centers as well as the importance of agency programs processed at the centers.

Generally, we found that the ODM&T assessments

--addressed the ADP general control areas at the data processing centers to include, for example, computer operations, system maintenance and development, application software controls, hardware controls, and physical security;

--considered the adequacy of controls in these areas; and

--identified ADP internal control weaknesses.

ODM&T rated each data processing center and its telecommunications service as highly vulnerable because of (1) the internal control weaknesses identified during the conduct of vulnerability assessments and (2) the lack of agency-wide ADP contingency plans to provide reasonable continuity of data processing support should events occur that prevent normal operations.

Because of the "highly vulnerable" ratings, in June 1984, ODM&T initiated quality assurance surveys at each data processing center. The surveys were designed to provide an introspective management view of the quality of ADP internal controls at each data processing center. While we did not conduct a detailed review of these surveys, we did observe instances where the surveys disclosed control weaknesses not identified in the vulnerability assessments. ODM&T has taken these control weaknesses and added them to its list of problems in need of corrective actions. This list also provides a schedule of planned corrective actions and estimated time of completion.

Of seven assessments we reviewed at the Hines data processing center, only the assessment of system maintenance and development addressed the adequacy of specific internal controls. In contrast, the assessment of computer operations at the center did not consider the adequacy of controls in place to ensure the accuracy and completeness of information maintained and processed by the center. Rather, this assessment and several others primarily considered such personnel-related concerns as employee morale, turnover, and job satisfaction. They did not consider the adequacy of specific controls during the assessment.

By not addressing specific controls, internal control weaknesses may have been overlooked. The managers at the Hines data processing center told us that the inconsistencies were due primarily to the lack of specific guidance for conducting vulnerability assessments. Therefore, the assessments conducted were subjective and the level of details provided a direct function of the assessors' experience and knowledge of internal control concepts. To improve the quality of the next round of vulnerability assessments, ODM&T plans to issue more specific guidance for conducting assessments.

ADP internal controls not adequately considered by DM&S

Similar to ODM&T, DM&S identified several ADP functions as assessable units and conducted vulnerability assessments. However, DM&S did not involve field managers in evaluating these ADP functions at its 172 hospitals. Therefore, the adequacy of ADP internal controls at VA hospitals was not assessed in FY 1984.

DM&S' Medical Information Resources Management Office identified and conducted assessments of 14 ADP-related units. These units represented such functions as system development, system operations, and technical assistance. The 14 units were composed of 7 VA central office activities and 7 field office counterparts.

OMB guidelines require agencies to establish an approach to ensure that multilocation programs and functions are covered in the evaluation. Further, OMB and VA guidelines state that internal control is the responsibility of the individuals managing the programs and functions. However, none of the assessments conducted by DM&S' Medical Information Resources Management Office involved field managers in evaluations of field ADP activities; these evaluations were made by central office personnel.

Improvements needed in ICRs

DVB's review of its $3.9 billion pension program concluded that adequate internal controls exist in the program. However, we found that the pension program ADP controls were not adequately evaluated and the ICR team did not consider existing system and internal control problems identified by the OIG.

As mentioned in chapter 4, we selected DVB's reviews of the pension and education programs for examination because VA identified material weaknesses in both programs in its annual report. In assessing them, we found that both reviews largely excluded the evaluation of ADP controls even though both programs depend on ADP systems for processing benefit claims. Of the two reviews, we selected the pension review to determine the extent to which the review team evaluated ADP controls and whether such evaluation supports DVB's opinion that adequate controls exist in the pension program.

Pension program ADP controls not adequately evaluated

OMB guidelines state that managers must assure that proper controls are in place in automated systems that support agency programs and functions. Further, when conducting internal control evaluations, managers must verify that such controls are working.

In reviewing the pension program ICR, we found that the pension review team generally considered ADP application controls governing data origination, input, and output, but did not adequately evaluate the application controls over the processing of the data. In addition, the ICR team did not obtain assurance as to the adequacy of ADP general controls. In the scope section of the report on the ICR, they stated that "We made no attempts to identify or test the internal controls present in the pay system itself." In our opinion, without properly evaluating processing controls, VA lacks an adequate basis to conclude that the pension program internal controls are functioning as they should.

Also, the VA pension program review team did not evaluate the adequacy of ADP general controls at the Hines data processing center where pension applications are processed. As a result, the review team had no assurance that pension applications were being processed adequately at the center. In addition, ODM&T rated the Hines center highly vulnerable. There is no indication that the review team considered the results of ODM&T's assessment of the Hines center.

We believe that a review of general controls at the Hines center is important to ascertain whether (1) the computer programs in automated systems process information as intended by management and (2) information submitted for computer processing is not added to, lost, or improperly manipulated during processing. The effectiveness of general controls must be addressed when evaluating ADP systems because weaknesses in general controls can adversely affect data being processed.

In our first report, we noted that VA did not adequately assess functional areas that overlapped organizational boundaries, such as ADP. Our discussions with VA officials indicated there was some uncertainty over which VA components should be involved in assessing the internal controls associated with the ADP systems. Further, VA guidance for internal control evaluations did not address how functions that cut across agency lines, such as ADP, should be addressed and what offices would be responsible. Consequently, we proposed that VA assign responsibility to assess functions that cut across department and office lines. VA concurred with our proposal.

In September 1984, VA issued revised guidance for assessing functions common among many components, such as ADP. In the case of ADP, the responsibility for the various ADP functions, such as security, computer operations, and data entry, may be divided among many VA components. Further, each of these components should consider ADP in areas in which they are responsible.

In response to the revised guidance, in November 1984, ODM&T in conjunction with DVB, a major user of ODM&T's services, developed a user applications control survey to involve users in the assessment of ADP systems for which both components share responsibility. Although VA made a good effort in FY 1984, the process was not sufficiently in place to assure coordination among VA components in evaluating crosscutting functions.

Existing system and internal control problems not reviewed by DVB

DVB concluded that adequate controls exist in its $3.9 billion pension program in spite of previously reported serious system and internal control problems. VA's OIG and GAO have reported in the past problems that may affect the accuracy and integrity of the pension program. However, those identified problems were not considered in the pension program ICR.

OMB guidelines state that audit reports submitted by the OIG, GAO, and others; internal evaluations; congressional reports; and consultants' reports should be reviewed for any indications that the program or administrative function had previously been subject to losses due to waste, loss, unauthorized use, or misappropriation.

In preparing for the pension review, the review team studied previous OIG and GAO reports relating to the program for background information and identified program problems. However, the team did not review any ADP-related reports addressing the pension program, believing such reviews of ADP-related issues to be outside the scope of its pension review. Even though the OIG had issued reports identifying system and internal control weaknesses in the pension systems, these weaknesses were not considered during the pension review.

The OIG report[1] stated that poorly documented software was an internal control weakness. According to the report, the pension system contains little formal documentation to describe and explain what specific functions the computer programs perform and the related logic involved. This problem has been cited on several occasions by the OIG. In fact, the OIG stated that the absence of documentation could ultimately undermine VA's ability to process and generate benefit payments to veterans.

We identified aging software as an internal control weakness. The software has been modified over the years, resulting in programs that are difficult to understand, modify, and test. In addition, because a number of experienced programmers have left the agency, staff expertise concerning the system operations is dwindling. As a result, VA does not completely understand how the system actually processes information, has difficulty maintaining it, and does not fully know if it accurately computes individual benefit payment amounts.

In addition, we found that the aging software problem has contributed to several instances of erroneous processing of veterans' benefits. For example, in March 1983, VA placed incorrect software logic into the production program that resulted in erroneous payments totaling about $2.2 million and involving over 9,000 checks. The lack of documentation provided little opportunity for programmers and system analysts to prevent the erroneous code from going into production. The Hines center researched the problem and corrected the processing logic. According to VA officials, the recovery actions required to identify and correct the erroneous payments were extensive and costly.

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[1] VA/OIG, Audit of Compensation and Pension Update Subsystem at the Hines Data Processing Center (3AD-G07-133), September 28, 1983.

In view of these problems, we believe it inappropriate for the pension program ICR to report that adequate internal controls exist in the program. Until VA corrects these problems, it cannot be assured that the pension program is protected from fraud, waste, and abuse.

SOME ADP CONTROL WEAKNESSES IDENTIFIED BY VA

Even though we believe that VA needed to better evaluate its ADP controls, the agency has identified some weaknesses and developed plans for correcting them. For example, in January 1984, ODM&T established a task force to review installation security for production application software at four agency-wide data processing centers and the Satellite Service Center because management believed there was a need for change to keep up with the state of the art. The task force reviewed current software security to determine (1) the adequacy of current policy and its implementation, (2) whether new standards are needed, and (3) the adequacy of current documentation.

Our review of the task force report, issued in July 1984, showed that ODM&T adequately considered ADP general controls associated with access to the production software. The task force identified 12 internal control weaknesses and made related recommendations. In addition, all data processing centers having the identified weaknesses were required to develop and implement plans for corrective action.

For example, the task force recommended that higher priority be given to security and control of production software by obtaining and using effectively the necessary security software tools. Managers' response to this recommendation ranged from the conduct of a review to assess current controls and acquiring, where applicable, security software (at the Philadelphia data processing center) to the installation of a security software package (at the Austin center). Our review of the centers' action plans showed that they were technically feasible to implement. But, until substantial actions are taken to rectify the identified weaknesses, VA agreed with us to report the lack of adequate security over production application software as a material weakness in its 1984 FMFIA report to the President and the Congress.

Further, to comply with OMB circular A-71, which requires agencies to develop appropriate contingency plans "to provide reasonable continuity of data processing should events occur which prevent normal operations," ODM&T has developed a multiphase plan that will require several years to implement. Therefore, VA reported the lack of contingency plans as a material weakness in its 1984 FMFIA report.

CONCLUSIONS

VA made progress in FY 1984 in evaluating ADP internal controls. The agency has revised its internal control guidance for assessing functions common among VA components, such as ADP, and assigned responsibility for assessing such controls. In addition, both ODM&T and DM&S identified ADP functions as assessable units and conducted vulnerability assessments.

But improvements are needed to assure that adequate evaluations of ADP controls are performed. We found that vulnerability assessments inconsistently evaluated ADP-assessable units and did not involve field managers to assess the adequacy of ADP controls at VA hospitals. In addition, the pension ICR team members did not recognize the program's vulnerability to known system and internal control weaknesses. We believe that the development of specific ADP guidance to assist managers in reviewing and evaluating ADP controls would help alleviate problems we identified by giving managers a consistent, complete approach.

RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator of Veterans Affairs require the Director, ODM&T, and the Chief Medical Director to develop more specific guidelines for reviewing ADP internal controls.

AGENCY COMMENTS

VA concurs with our recommendation and stated that ODM&T is adapting the U.S. Department of Energy publication, "ADP Internal Control Guidelines," and ODM&T plans to use a similar approach for its FY 1986 vulnerability assessments. VA further noted that DM&S has developed a comprehensive ADP policy circular, "Department of Medicine and Surgery ADP Security Policy and Guidelines," covering all aspects of ADP security at DM&S's medical centers. The publication and distribution of this DM&S circular to the medical centers are anticipated by early November 1985.

CHAPTER 7

IMPROVEMENTS NEEDED TO CORRECT ACCOUNTING SYSTEM WEAKNESSES

In its 1984 annual report to the President and the Congress, as required by section 4 of FMFIA, VA reported that its accounting systems generally conform in all material aspects to the accounting principles, standards, and related requirements prescribed by the Comptroller General.[1] It did, however, point out exceptions to this overall conclusion and identified significant weaknesses in cash management, fund control, and VA's ability to reconcile some major disbursement control accounts with source documents. This is in contrast with VA's 1983 annual report, which identified no significant weaknesses.

Our evaluation has shown VA's evaluation of its accounting systems to be limited. We believe these efforts do not provide an adequate basis to form an overall conclusion, and VA is not yet in a position to report on whether its accounting systems conform to the Comptroller General's requirements. We found that VA's efforts:

--Did not include testing of some subsystem operations for conformance with the Comptroller General's requirements. For example, VA omitted those which process, control, and report on transactions for its major assets, such as cash receipts, medical supplies and equipment, and receivables, or for its major liabilities.

--Were limited to statistical tests of procedures for processing disbursement transactions, which did not fully consider systems procedures and controls for authorization and financial reporting functions.

--Did not address the ADP application controls in its systems.

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[1] The GAO Policy and Procedures Manual for Guidance of Federal Agencies contains the principles, standards, and related requirements to be observed by federal agencies. Specifically, title 2 prescribes the overall accounting principles and standards, while titles 4, 5, 6, and 7 govern, respectively: claims; transportation; pay, leave and allowances; and fiscal procedures. Also, agency accounting systems must include internal controls standards and related requirements, such as the Treasury Financial Manual and OMB circulars.

In addition, VA did not consider or report on the need to improve its basic financial management systems because its automated systems do not effectively support internal controls over financial information or managers' needs for timely financial information. Recognizing these problems, VA plans to spend $244 million over 5 years to enhance its ADP operations.

VA must improve its accounting system evaluations before it will be able to clearly determine the degree to which its accounting systems conform to the Comptroller General's requirements. The scope of evaluations should be broadened to the total inventory of accounting systems and the problems associated with updating VA's antiquated ADP systems. VA also should improve the quality of its systems tests. In recognition of these needs, VA in late 1984 established a Controls Analysis Risk Evaluation Group to identify and correct deficiencies in its accounting systems.

PROBLEMS IDENTIFIED IN ACCOUNTING SYSTEMS AND CORRECTIVE ACTIONS TAKEN

While limited and in need of improvement, VA's efforts in FY 1984 identified significant system-wide weaknesses in its Centralized Accounting for Local Management and Loan Guarantee Program disbursement systems. These weaknesses resulted in

- --a significant number of violations of the Prompt Payment Act, which requires federal agencies to pay interest on overdue payments to private contractors,
- --improper obligations and disbursements of funds, and
- --inaccurate financial data because control accounts were not reconciled with source documents.

Also, VA reported a number of individual instances of field facilities' nonconformance with the Comptroller General's requirements. These resulted in such problems as excessive travel advances outstanding, excessive petty cash funds at agent cashiers, and poor debt-collection practices. The problems were identified in OIG compliance audits of individual field facilities and internal control reviews. Although found at only one or at a limited number of field facilities, these weaknesses were included by VA because VA managers believed they could indicate problems of broader scope.

VA intends to correct noncompliance with the Prompt Payment Act in several ways. In the case of the Centralized Accounting for Local Management system, which makes about 3 million payments yearly, it plans to develop an automated subsystem to reconcile accounts payable document files with other systems records and reduce processing time for payments by 5 days. In the Loan Guarantee Program system, which makes substantially fewer payments, VA plans to stress in training seminars the need to comply with system procedures over the flow and date stamping of documents. During field surveys of program activity accounted for by this system, VA plans to monitor progress in making timely payments.

Problems identified in OIG reports at only one or few locations generally happened because prescribed procedures were not followed. VA field facility managers stated that they have taken or plan to take action to correct the individual deficiencies. In addition, field facility managers plan to take more aggressive action to monitor control procedures in accounting systems to assure the deficiencies do not occur or recur at any field facilities. For example, VA management has formally requested the OIG to perform more fiscal compliance auditing of accounting reconciliation processes and efforts to collect past-due accounts receivable.

Also, operating procedures for existing VA accounting systems have several built-in tests that can help VA managers control the accuracy of financial data (e.g., determining whether payments are timely and properly authorized). Using its automated follow-up system, VA plans to track accounting problems identified through these tests.

We believe these represent reasonable efforts to correct identified deficiencies. If VA follows through on its planned monitoring efforts, it should be able to correct the deficiencies identified in its FY 1984 reviews of accounting systems and, should the deficiencies recur, remedy them quickly. However, these efforts will have little effect on the major system problems not reported by VA in FY 1984, which we discuss below.

MAJOR SYSTEM PROBLEMS NOT REPORTED

While VA reported certain accounting system weaknesses in 1984, its reporting was incomplete. VA's current financial management systems neither (1) effectively support managers' needs for timely information nor (2) support effective internal controls over financial information. Timeliness and adequate internal controls are two important elements of the Comptroller General's accounting principles and standards. Compliance with these standards is necessary so that data produced by an accounting system will be of maximum use in support of a manager's decisions concerning the control and use of available resources.

VA recognized these problems in preparing its 5-year ADP and telecommunications plans for 1985-89. These plans provide for 52 major automated systems development projects and 5 major procurements of ADP equipment. VA estimates the cost of these initiatives at more than $244 million--about $191 million for system development projects and almost $53 million for equipment procurement. The plan includes 44 financial management systems projects, which represent a virtual overhaul of VA's financial management structure.

In short, VA's problems with its automated financial systems center around the systems' shortcomings concerning management information needs and internal controls. These problems occur because VA's current systems are outdated and slow and are designed around obsolete techniques. The systems are incapable of taking advantage of modern data entry, telecommunications, and data-base management techniques. Although VA recognized the need to correct accounting and financial management system problems in its ADP plan, it did not consider or report them in its 1984 FMFIA statement on accounting systems.

Overall, the systems development projects are in the system study and technical design stages. Thus, we cannot now assess whether these projects will, in fact, meet design goals when implemented. As part of its continuing systems development, VA should monitor these efforts closely to assure that the new systems are designed to operate in conformity with the Comptroller General's requirements.

PROGRESS MADE IN EVALUATING ACCOUNTING SYSTEMS, BUT MORE IMPROVEMENTS NEEDED

As discussed below, VA has made limited progress in FY 1984 to evaluate and test its accounting systems to determine if they are in comformance with the Comptroller General's requirements, but major problems still exist with the evaluation process.

In September 1983, at a conference with representatives of OMB, VA, and other federal agencies, the Comptroller General suggested methods to build on the results of the agencies' first-year efforts. These methods included validating the accounting systems inventory, initiating systems upgrade projects, documenting the agency's overall accounting system structure, evaluating the systems in operation to be sure they include testing, and developing and implementing short- and long-range plans to correct deficiencies.

Although VA's efforts to assess its accounting systems during FY 1984 represent steps forward, it did not put the suggested methods in place to the extent necessary to assure conformance. VA used statistical sampling techniques to test and identify weaknesses in its disbursements. Comparing VA's FY 1984 review of its accounting systems with those of FY 1983, we noted significant weaknesses identified in two disbursement systems and less significant weaknesses in others, and initiation of actions to correct them. VA also began to inventory operating accounting systems and established in late 1984 a Controls Analysis Risk Evaluation Group within the OB&F (Controller) that will have responsibility for future reviews of accounting systems.

Before it will have in place an evaluation method capable of identifying major system weaknesses and providing an adequate basis for reporting on the conformity of its accounting systems with the Comptroller General's requirements, VA should:

1. Improve the quality of its systems tests and specifically consider ADP controls in systems reviews.

2. Broaden the evaluation to consider its total inventory of accounting systems and the improvements needed to update its antiquated ADP accounting systems.

3. Develop a plan to efficiently perform these activities in a reasonable period of time.

Improvement needed in tests of disbursement systems

During its FY 1984 efforts, VA identified some significant areas of nonconformance with the Comptroller General's requirements by making limited tests of its six major disbursement systems. The tests were done in response to a proposal in our report on VA's 1983 implementation of FMFIA that the agency selectively test accounting transactions from the point a transaction is authorized through processing of data to issuance of financial or management reports. VA made a start in the direction we suggested by systematically sampling various attributes of disbursements from its six major disbursement systems.

VA sought to determine if timely payments were made in the proper amount to the correct payee. In performing the tests, VA selected statistical samples of amounts paid by each of its disbursement systems and traced the dollar amounts and payees' names back to authorization documents in files at VA offices and hospitals. The tests were, however, limited to procedures to assure proper processing of transactions. VA did not address proper authorization and financial reporting of transactions or ADP controls.

Were the authorization of transactions tested, we think that VA would have identified additional problems. For example, accounting data VA officials gave us show that, in each of the past 2 fiscal years, $400 million of overpayments resulted from improper authorization in VA's pension, compensation, and readjustment benefit programs. To assure adequate controls over the total process of accounting transactions, authorization to final reporting, OB&F should include testing of transaction authorization as part of its accounting systems reviews. This could be done in conjunction with internal control evaluations of program authorization procedures.

Nor did VA's tests of its systems consider controls over the financial reporting function. As noted in the previous section of this chapter, timeliness of financial reporting is a major problem that needs to be corrected during VA's efforts to modernize its ADP systems.

Because they are an integral part of the operation of its accounting systems, VA also needs to test ADP internal controls built into its automated accounting systems. To determine whether a financial system conforms to principles, standards, and related requirements prescribed by the Comptroller General, it is necessary to review and test the system in operation. Although agency personnel may have extensive system knowledge, a system may operate differently than they believe. Therefore, testing should be done on critical aspects of the system and may include

--interviewing persons who operate the system,

--observing operating procedures,

--examining system documentation,

--applying procedures to live transactions and comparing results,

--direct testing of computer-based systems by use of simulated transactions, and

--reviewing error reports and evaluating error follow-up procedures.

Tests should be designed to disclose whether the system processes valid transactions properly and rejects invalid transactions. The tests should cover both manual and automated operations, from initial authorization through processing, posting to the accounts, and reporting. In developing test plans, consideration should be given to the results of any prior system testing.

This testing criterion has been adopted by OMB and included in Appendix H of its publication, "Guidelines for Evaluating Financial Management/Accounting Systems" (May 20, 1985). In determining tests appropriate for an accounting system, using transaction testing as the key, usually more than one of the above techniques are needed to test all important aspects of the system.

System reviews of broader scope achievable through an overall assessment plan

VA efforts to assess its accounting systems in FY 1983 and 1984 were not part of an overall plan that considered the total inventory of systems. Instead, in FY 1983, VA limited its efforts to comparing its accounting policies for its six major disbursement systems with the Comptroller General's principles and standards and in FY 1984 made limited tests of these systems.

We agree that VA disbursement systems deserve priority attention because of the risks associated with making payments under its complex rules and regulations. However, other subsystems that help VA control and manage billions of dollars of resources also need to be evaluated.

Before this evaluation can take place, VA has to identify its total inventory of accounting systems. As part of our efforts to assist agencies in improving their accounting systems, we are working with VA to identify the major subsystems that comprise its total accounting structure. For example, in March 1985, we provided VA with a list of 57 automated subsystems that capture, record, summarize, and report information on the execution of VA's budget authority and the financial results of its programs and administrative functions. This list, which we developed as part of a financial management profile of VA, will help the agency identify the accounting systems to be reviewed, both for conformance to the Comptroller General's requirements and as part of VA's plan to modernize its ADP accounting systems. For FY 1985, VA requested its operating divisions to review this list and confirm whether it represents the total number of subsystems in its overall accounting system.

To date, VA has not adequately reviewed or tested significant subsystems of its total accounting structure. For example, the agency did not test or otherwise review subsystems that process, control, and report on transactions for its major assets (e.g., cash receipts, medical supplies and equipment, and receivables) and major liabilities. These systems report on and help VA manage and control billions of dollars of resources used to provide benefits and services to veterans. For the Administrator of Veterans Affairs to have an adequate basis to report on its accounting systems, VA needs to thoroughly review and test these systems.

A formal plan could help assure VA managers that its complex structure of accounting subsystems will be addressed over a reasonable period of time and that ongoing major systems redesign efforts will be fully considered.

Of the 57 subsystems we identified, 44 are being designed or redesigned under VA's 5-year ADP modernization plan. VA needs to coordinate its systems review efforts with redesign plans to assure that

--current efforts are limited to identifying cost-effective short-term solutions to known systems problems that will be corrected under new designs in the near future,

--systems are being redesigned to operate in conformance with the Comptroller General's requirements, and

--all significant problems with existing systems that may be discovered through redesign efforts are reported under FMFIA.

FRAMEWORK FOR ADEQUATE ASSESSMENTS PROVIDED BY NEW GROUP

As we mentioned previously (see p. 56), VA has recognized that its evaluation approach was not adequate. In late 1984, VA established a Controls Analysis Risk Evaluation Group within OB&F to:

--Perform annual reviews of VA's accounting systems to determine whether the systems conform to the Comptroller General's requirements. In performing this task, the group will have responsibility for (1) maintaining an inventory of the agency accounting systems, (2) documenting the accounting system structure, (3) performing risk analysis and statistically valid tests of the systems, and (4) developing plans for needed improvements.

--Coordinate and oversee VA-wide efforts to evaluate improvements and report on VA financial management/accounting systems, including participation in government-wide efforts to develop a standard accounting system.

--Organize and conduct detailed examinations of VA controller operations to determine if adequate control measures have been implemented to prevent or detect potential risks.

--Develop and maintain a strategic plan for upgrading and integrating the present VA accounting systems into a streamlined overall financial management system providing timely, reliable, and consistent information.

Since the new evaluation group has been in operation for only a short time, it is too soon to assess its effectiveness. However, we are encouraged by this initiative. If the new group is successful in performing its assigned responsibilities, it should provide VA with a solid framework to identify and correct deficiencies in its operating accounting systems in future years.

VA still needs to develop a definitive plan to put in place the evaluation process for which the group has responsibility. The plan should establish time frames and resources required by the group to achieve its objectives and responsibilities in a reasonable period. Such a plan is particularly important in the case of VA, which has begun a major modernization effort for its automated systems. The plan would also give the agency an adequate basis to report annually, as required by FMFIA, as to whether its accounting systems conform to the Comptroller General's requirements.

CONCLUSIONS

Although VA made some progress in testing system operations and initiating corrective actions on identified weaknesses, its efforts in FY 1984 were disappointing, largely because the agency did not approach its job on a well planned basis and limited its efforts to only one major function of its systems--control of disbursements. Other functions, such as accounting for assets and liabilities, need to be evaluated and tested as well. Also, the efforts were limited in scope and not adequate in most instances to determine conformance with the Comptroller General's requirements.

Although its efforts in FY 1984 to comply with the requirements of section 4 were an improvement over FY 1983, VA needs to make further improvements to identify and correct accounting system weaknesses and to have an adequate basis to report on their conformity. VA needs to:

- --Broaden the scope of accounting systems reviews to include tests of the subsystems that process, control, and report on transactions for its major assets (such as cash receipts, medical supplies and equipment, and receivables) and major liabilities.

- --Adequately test all aspects of the transactions from authorization to final reporting in its financial statements and address ADP controls built into the system.

- --Coordinate these efforts with ICRs and ADP modernization plans so that all weaknesses found can be corrected.

VA took a major step in the right direction by establishing a group in OB&F to oversee improvements in its accounting systems, but it must continue to assure that top management remains committed to continued improvements.

RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We believe that VA should not report that its accounting systems conform with the Comptroller General's requirements until the systems have been adequately evaluated in operation. Therefore, we recommend that the Administrator of Veterans Affairs require the Director, OB&F (Controller), to develop an overall plan for reviewing VA's accounting structure to provide an adequate basis for meeting the reporting requirements of section 4 of FMFIA. The plan should provide that

- --major subsystems of VA's accounting structure are reviewed in a reasonable period of time and in priority order based on the significant risks in each of the subsystems--especially the risks associated with systems problems that are being corrected by VA's 5-year ADP plan,

- --reviews of systems include tests of transactions from their authorization through processing of data (either manually or automatically) to issuance of financial reports, including testing of ADP controls where appropriate,

- --reviews of accounting systems be coordinated with reviews of controls that authorize disbursements for VA benefit and medical programs, so that accuracy of systems reporting can be evaluated in total, and

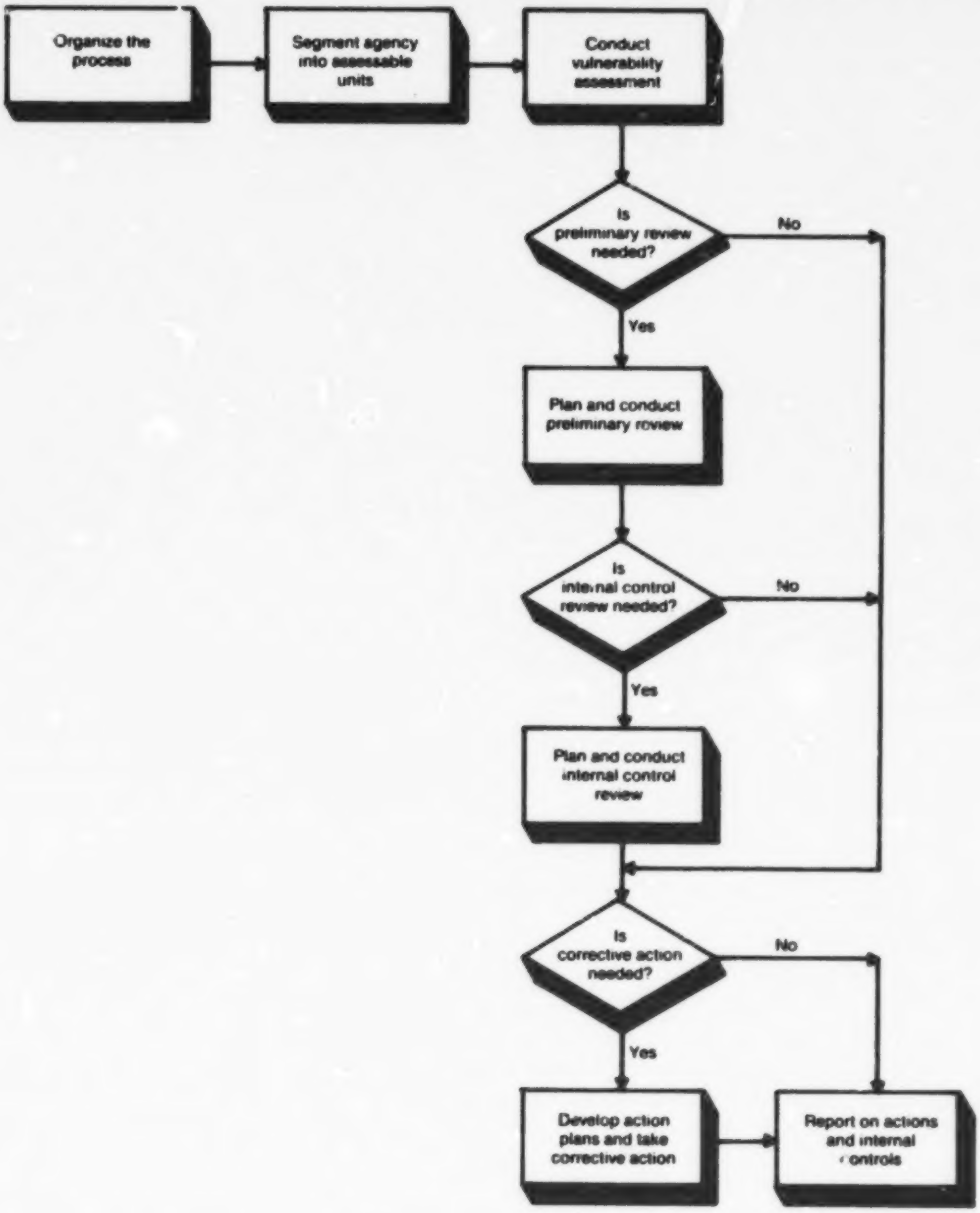
--reviews of accounting systems be done in conjunction with and in support of VA's 5-year ADP plan, so that deficiencies found in ADP portions of the accounting systems can be corrected as the 5-year plan is implemented.

AGENCY COMMENTS

VA pointed out that guidance in OMB circular A-127 provides a comprehensive process of planning, evaluation, and review for financial management systems, and stated that OB&F will use this process for its third-year effort. VA further commented that, beginning in FY 1986, major system components will be subjected to a detailed review, including transaction testing and user surveys. The agency also pointed out that systems will be evaluated on a 3-year schedule, with risk being one consideration in the scheduling.

In addition, VA commented that all systems will be given a limited annual review; instances of nonconformance to appropriate principles and standards, including GAO's title 2, will be recorded and used to effect revisions to a long-range plan for financial management systems. Lastly, the agency stated that it believes that the OMB circular provides a vehicle for addressing the above recommendation.

Figure I.1: Veterans Administration Process for Compliance With the Federal Managers' Financial Integrity Act.


Organize the process
Segment agency into assessable units
Conduct vulnerability assessment
Is preliminary review needed?
No
Yes
Plan and conduct preliminary review
Is internal control review needed?
No
Yes
Plan and conduct internal control review
Is corrective action needed?
No
Yes
Develop action plans and take corrective action
Report on actions and internal controls

VETERANS ADMINISTRATION'S
INVENTORY OF
ORGANIZATIONAL COMPONENTS

OFFICE OF THE ADMINISTRATOR

OFFICES OF THE ASSOCIATE DEPUTY ADMINISTRATORS

Associate Deputy Administrator for Congressional and Intergovernmental Affairs

Associate Deputy Administrator for Public and Consumer Affairs

Associate Deputy Administrator for Information Resources Management

Associate Deputy Administrator for Logistics

DEPARTMENTS

Department of Medicine and Surgery

Department of Veterans Benefits

Department of Memorial Affairs

OFFICES

Office of Small and Disadvantaged Business Utilization

Office of Administration

Office of Budget and Finance

Office of Personnel and Labor Relations

Office of Program Planning and Evaluation

Office of Construction

Office of Data Management and Telecommunications

Office of Information Management and Statistics

Office of Procurement and Supply

Office of the General Counsel

Office of the Inspector General

Office of Equal Opportunity

BOARDS

Board of Veterans Appeals

Board of Contract Appeals

VULNERABILITY ASSESSMENTS REPORTED BY

THE VETERANS ADMINISTRATION IN FY 1984

Component	Number of program/ administrative functions	Number of assessable units	Level of vulnerability		
			High	Moderate	Low
Office of the Administrator	1	1	0	0	1
Office of the Associate Deputy Administrator for Congressional and Intergovernmental Affairs	1	1	0	0	1
Office of the Associate Deputy Administrator for Public and Consumer Affairs	1	1	0	0	1
Office of the Associate Deputy Administrator for Information and Resources Management	1	1	0	0	1
Office of the Associate Deputy Administrator for Logistics	1	1	0	1	0
Department of Medicine and Surgery	46	252	12	35	205
Office of Construction	15	15	5	7	3
Office of Personnel and Labor Relations	10	10	0	3	7
Office of Information Management and Statistics	1	12	0	2	10
Office of Data Management and Telecommunications	5	18	6	8	4
Office of Procurement and Supply	4	8	0	8	0
Office of Administration	4	5	0	0	5
Office of Program Planning and Evaluation	4	9	0	0	9
Board of Contract Appeals	1	1	0	0	1
Board of Veterans Appeals	1	2	0	0	2
Office of Equal Opportunity	3	6	1	0	5
Office of the General Counsel	4	4	0	1	3
Total	103	347	24	65	258

PRELIMINARY REVIEWS REPORTED BY THE VETERANS ADMINISTRATION IN FY 1984

Component	Number of preliminary reviews	Latest vulnerability assessment rankings High	Moderate	Low
Office of the Associate Deputy Administrator for Public and Consumer Affairs	1	0	0	1
Department of Veterans Benefits	2	0	0	2
Department of Medicine and Surgery	1[a]	1	0	0
Department of Memorial Affairs	2	2	0	0
Office of Construction	5	5	0	0
Office of Personnel and Labor Relations	3	0	0	3
Office of Procurement and Supply	7	0	7	0
Office of Information and Statistics	2	0	0	2
Office of Equal Opportunity	1	1	0	0
Board of Veterans Appeals	1	0	0	1
Total	25	9	7	9

[a] While DM&S reportedly made an effort at the field level to do preliminary reviews in 19 areas, we were only able to locate 1 summary review done at the central office.

INTERNAL CONTROL REVIEWS REPORTED BY THE VETERANS ADMINISTRATION IN FY 1984

Component	Description of internal control review
Department of Veterans Benefits	Pension processing Education processing
Office of Data Management and Telecommunications	Internal security Direct deposit/electronic funds transfer processing
Office of Budget and Finance	Centralized Accounting System for construction appropriations Personnel Accounting Integrated Data System and station payroll Centralized Accounting for Local Management (CALM) System Quality of CALM System subsidiary records Timeliness of CALM System payments Statistical Sampling Plan for CALM System payments
Office of the Inspector General	Financial management
Department of Memorial Affairs	Obtaining property and services
Office of Program Planning and Evaluation	Contractual services
Board of Veterans Appeals	Security of claims folders

MATERIAL WEAKNESSES REPORTED
BY THE VETERANS ADMINISTRATION
IN ITS SECOND ANNUAL REPORT

The Veterans Administration identified 14 areas of material weakness during its internal control and accounting systems' evaluations and reported them in its second annual statement to the President and the Congress dated December 27, 1984:

WEAKNESSES FOR WHICH CORRECTIVE ACTIONS HAVE BEEN TAKEN

Appropriation/financial program tracking system.

Fee basis contract hospitalization.

AGENCY-WIDE MATERIAL WEAKNESSES REQUIRING CORRECTIVE ACTIONS

Compliance with the Prompt Payment Act.

Reconciliation of control accounts to source documents.

ORGANIZATION-SPECIFIC MATERIAL WEAKNESSES REQUIRING CORRECTIVE ACTIONS

Inpatient drug distribution system.

Textile care.

Civilian Health and Medical Program of the VA.

Compensation and pension processing and procedures.

Education processing and procedures.

Modernization of the Department of Veterans Benefits through technology.

Computer security.

Comprehensive study of VA's organization and procedures for constructing health care facilities.

Improvements in project design and construction.

Field finance processing and procedures.

VETERANS ADMINISTRATION'S ORGANIZATIONS AND FACILITIES VISITED

CENTRAL OFFICE (Washington, D.C.)

Office of the Associate Deputy Administrator for Information Resources Management
Department of Medicine and Surgery
Department of Veterans Benefits
Office of Budget and Finance
Office of Data Management and Telecommunications
Office of Procurement and Supply
Office of Construction
Office of the Inspector General
Management Control Staff

MEDICAL CENTERS

Danville, Illinois
Kerrville, Texas
Marlin, Texas
Ann Arbor, Michigan
Philadelphia, Pennsylvania
Coatesville, Pennsylvania

REGIONAL OFFICES

Chicago, Illinois
Houston, Texas
Waco, Texas
Wilmington, Delaware
Philadelphia, Pennsylvania
Milwaukee, Wisconsin
Indianapolis, Indiana

DATA PROCESSING CENTERS

Austin, Texas
Hines, Illinois
St. Paul, Minnesota

REGIONAL MEDICAL EDUCATION CENTERS

South Central Regional Medical Education Center, St. Louis, Missouri
Northeast Regional Medical Education Center, Northport, New York
North Central Regional Medical Education Center, Minneapolis, Minnesota

INSURANCE CENTER

Philadelphia Insurance Center, Philadelphia, Pennsylvania

VETERANS ADMINISTRATION

APPROPRIATIONS FOR FY 1984 AND 1985

Appropriation/fund account	FY 1984	FY 1985
	(thousands)	
Benefits programs:		
Compensation and pensions	$14,126,900	$14,167,900
Readjustment benefits	1,453,200	1,182,000
Veterans insurance and indemnities	7,400	11,000
Reinstated entitlements program for survivors	51,000	0
Emergency veterans job training	150,000	0
Loan guaranty revolving fund	100,000	306,600
Total benefits programs	15,888,500	15,667,500
Medical programs:		
Medical care	8,244,414	8,854,428
Medical and prosthetic research	217,680	192,372
Medical administrative and miscellaneous operating expenses	66,552	67,891
Grants for construction of state extended care facilities	18,000	34,500
Grants to Republic of Philippines	500	500
Total medical programs	8,547,146	9,149,691
Construction programs:		
Construction, major projects	345,692	568,194
Construction, minor projects	185,378	199,823
Total construction programs	531,070	768,017
General operating expenses and miscellaneous:		
General operating expenses	715,676	754,052
Grants for construction of state veterans cemeteries	3,000	5,000
Total general operating expenses and miscellaneous	718,676	759,052
Total appropriations	$25,685,392	$26,344,260

VETERANS ADMINISTRATION

FACILITIES AND EMPLOYMENT

FACILITIES

	Central office
226	Outpatient clinics
172	Hospitals
137	Outreach program centers
109	National cemeteries
105	Nursing care units
58	Regional offices
17	VA offices (DVB)
16	Domiciliaries
5	Data processing centers
3	Supply depots
3	National cemetery area offices
3	Canteen service field offices
2	Insurance centers
1	Marketing center
1	Canteen finance center
1	Prosthetic center
1	Prosthetic distribution center
1	Records processing center
1	Foreign office (Manila)

Note: Data as of December 31, 1984.

EMPLOYMENT

Central office		4,695
Field facilities		235,228
Medical centers (separate)	190,619	
Domiciliaries and medical centers	18,359	
Regional offices (separate)	11,811	
Regional offices and medical centers	7,886	
Regional offices and insurance centers	1,679	
Independent outpatient clinics	1,269	
Data processing centers	1,856	
National cemeteries	1,003	
Supply depots and marketing center	429	
Miscellaneous activities (canteen field offices, national cemetery area offices, records processing center, prosthetics, prosthetic distribution center, and canteen finance center)	317	
Total		239,923

Note: Data as of September 30, 1984.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

SEP 6 1985

Mr. Richard L. Fogel
Director, Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

Your July 17, 1985 draft report "Veterans Administration's Second-Year Implementation of the Federal Managers' Financial Integrity Act" has been reviewed by our departments and staff offices. I concur with the recommendations but have definite reservations about the need to implement them in precisely the manner the General Accounting Office (GAO) recommends.

GAO believes the Veterans Administration (VA) does not have an adequate basis to state that its internal controls and accounting systems, taken as a whole, comply with requirements of the Federal Managers' Financial Integrity Act (FMFIA) to provide reasonable assurance that the objectives of the Act were achieved. The basis for GAO's statement is primarily the significance of the uncorrected weaknesses and instances of nonconformance reported by the VA. Although I agree that we have weaknesses and that all corrective action has not been implemented, I believe that GAO does not give adequate recognition to other available information that is used by VA to provide this assurance. In addition, GAO does not acknowledge the significant improvements and progress this Agency made in the overall implementation process. I do not agree with GAO's conclusion that the VA is unable to provide reasonable assurance that it complies with the objectives of the FMFIA. GAO places undue emphasis on the model process suggested by Office of Management and Budget (OMB) Circular A-123 (A-123) and the OMB Guidelines while failing to recognize that other available information can provide this assurance.

Processes such as vulnerability assessments can be accomplished in many ways. Routine staff meetings can often accomplish the same purpose and can occur more frequently than formal biennial vulnerability assessments. The adequacy of the existing systems used to identify significant control weaknesses should be addressed. I agree that we need to systematically assess control vulnerabilities, but GAO should recognize the need to make maximum use of existing management processes that accomplish control objectives without adhering to a rote process.

GAO's failure to address the cost implications of implementing the Financial Integrity Act is of major concern to this Agency. Guidance from both GAO and OMB stress the need to weigh the benefits of controls against their cost. OMB's model evaluation system can be very paper- and labor-intensive. In order to prevent unnecessary effort, both OMB and VA have always encouraged a high degree of individual tailoring of the model system. VA's major concern is to emphasize cost-effective controls, not necessarily follow a rote process or merely take existing documents and rephrase them in FMFIA terminology.

Mr. Richard L. Fogel

The report also fails to recognize that guidance for implementing Section 4 of the FMFIA was limited. It would have been helpful if OMB or GAO could have furnished additional guidance for implementing Section 4. For the most part, the VA pioneered in developing the necessary processes. In fact, our initiative and experience significantly contributed to the guidance that was subsequently issued by OMB.

Comments on the recommendations are enclosed. Thank you for the opportunity to review the report.

Sincerely,

Everett Alvarez Jr

HARRY N. WALTERS
Administrator

Deputy Administrator • For

Enclosure

VETERANS ADMINISTRATION RESPONSE TO THE JULY 17, 1985 GAO DRAFT REPORT "VETERANS ADMINISTRATION'S SECOND-YEAR IMPLEMENTATION OF THE FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT"

GAO recommends that I require VA departments and offices to

—document existing internal controls for each assessable unit.

—include (1) an analysis of the general internal control environment, (2) an evaluation of inherent risks, (3) a preliminary evaluation of safeguards, and (4) a summary of the assessment results for all vulnerability assessments;

—include documentation in vulnerability assessments of what was assessed and who assessed it, and an analysis of the vulnerability of each assessable unit;

—identify and analyze pertinent problems and concerns during preliminary reviews and select, implement, and track appropriate follow-up actions to correct them; and

—obtain sufficient documentation during preliminary reviews to support the findings and conclusions contained therein.

We share GAO's concern for improved documentation; however, many of the documentation issues result from the fact that the system is new and in developing stages. The need for improved documentation was addressed in the September 28, 1984 revision to VA Manual MP-1, Part II, Chapter 15 and we will continue to emphasize this in future contacts with VA components. In addition to the revised manual chapter, a draft vulnerability assessment workbook has been developed to assist VA components in the design and conduct of vulnerability assessments. A copy of the draft workbook was provided to GAO. We believe that vulnerability assessments should not be expected to do more than help determine a level of vulnerability and provide information needed to develop a plan for subsequent actions; detailed documentation should not be required.

GAO recommends that I require VA departments and offices to

—provide training to Internal Control Review (ICR) team members on the internal control review process, including documentation requirements;

—fully comply with the agency's nine-st approach for conducting ICR's; and

—implement corrective actions recommended by ICR's and track the actions to determine whether internal controls were strengthened.

We agree with the intent of these recommendations and recognize that adequate documentation of actions following vulnerability assessments is necessary. However, we believe GAO has placed too much emphasis on ICR's that follow a model process rather than the broad range of possible actions that may be appropriate. The Preliminary Review and ICR Guidelines that VA has published are intended to be training instruments that provide review teams with a model process, but each team must decide whether or not the model is the best approach. Rather than train ICR teams in a fixed approach, we prefer broad-based training that encompasses determining the best course of action. In order to improve the tracking system and ensure that appropriate corrective actions are implemented, we have modified the VA's Master Calendar. Internal control officials in various VA components have been advised of the need to improve the reporting of corrective actions.

In the Department of Medicine and Surgery, training on A-123 requirements was conducted for both Central Office and field personnel during Fiscal Year (FY) 1984. The instruction included the nine-step approach involved in the internal review process. Corrective action tracking and followup are accomplished through DM&S' Systematic Internal Review Program.

GAO recommends that I direct:

—the Chief Benefits Director to require regional offices to analyze the sources of problems surfaced by the reviews required by DVB Circular 20-84-20 and other processes;

—the Chief Benefits Director and the Chief Medical Director to require that each field facility implement a formal, centralized tracking and followup system that incorporates identified internal control weaknesses from all sources; and

—the Chief Benefits Director to require regional offices to train managers who are responsible for internal control evaluations.

I concur in these recommendations. DVB issued their July 5, 1984 Circular 20-84-20 "Internal Control Systems" to, among other things, bring DVB field stations into the internal control process. Since field station directors could not be expected to provide a well-documented statement of written assurance in the approximately 2½ months then remaining in FY 1984, the Circular did not require the statements of assurance until the end of FY 1985. DM&S currently requires medical facilities to establish a formalized tracking and followup system within the Systematic Internal Review Program.

GAO recommends that I require

—the Director, ODM&T, and the Chief Medical Director to develop guidelines for reviewing ADP internal controls.

I concur. The Office of Data Management and Telecommunications (ODM&T) is adapting the Department of Energy publication "ADP Internal Control Guidelines" and plans to use a similar approach for its FY 1986 vulnerability assessments. DM&S has developed a comprehensive ADP policy circular "Department of Medicine and Surgery ADP Security Policy and Guidelines" that covers all aspects of ADP security in VA medical centers. Publication and distribution to field facilities is anticipated within the next 2 months.

GAO recommends that I require the Director, Office of Budget and Finance (Controller) to develop an overall plan for reviewing VA's accounting structure to provide an adequate basis for meeting the reporting requirements of Section 4 of the FMFIA. The plan should provide that:

—Major subsystems of VA's accounting structure are reviewed in a reasonable period of time and in priority order based on the significant risks in each of the subsystems—especially the risks associated with systems problems being corrected by VA's 5-year ADP plan.

—Reviews of systems include tests of transactions from their authorization through processing of data (either manually or automatically) to issuance of financial reports, including testing of ADP controls where appropriate.

—Reviews of accounting systems be coordinated with reviews of controls that authorized disbursements for VA benefit and medical programs so that accuracy of systems reporting can be evaluated in total.

—Reviews of accounting systems be done in conjunction with, and in support of, VA's 5-year ADP plans so that deficiencies found in ADP portions of the accounting systems can be corrected as the 5-year plan is implemented.

The guidance in OMB Circular A-127 provides a comprehensive process of planning, evaluation, and review for financial management systems. The Office of Budget and Finance will use this program for their third year effort. Beginning in FY 1986, major system components will be subjected to a detailed review, including transaction testing and user surveys. Systems will be evaluated on a 3-year schedule, with risk being one consideration in the scheduling. In addition, all systems will be given a limited annual review. Instances of nonconformance to appropriate principles and standards, including GAO's Title 2, will be recorded and used to effect revisions to a long range plan for financial management systems. We believe the A-127 process will provide a vehicle for addressing most of the GAO recommendations concerning Section 4 of the FMFIA.

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